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CONTENTS

THE MASSACHUSETTS MEDICAL SOCIETY

Proceedings of the Council 755

BOSTON SURGICAL SOCIETY, INC.

The Presentation of the Henry Jacob Bigelow Medal 758

Bronchoscopy; Past, Present and Future. *Chevalier Jackson* 759

The Trend in Legal Forms Used in Admitting Patients to the Danvers State Hospital. *Neil A. Dayton* and *Helen H. Dolan* 764

Fistula an Etiological Factor in Rectal Carcinoma. *S. M. Fitchet* 766

Nursing and Maternal Welfare. *Stephen Rushmore* 768

The Diagnostic Value of Cholecystography. *Frederick T. Lord* 773

The Effect of Lateral Posture in the Examination of the Chest. *Harold W. Dana* 774

THE NEW ENGLAND MEDICAL COUNCIL

Education of the Public with Respect to the Cults. *Thomas J. O'Brien* 777

Education of the Public with Respect to Public Health Problems. *William G. Ricker* 782

CASE RECORDS OF THE MASSACHUSETTS GENERAL HOSPITAL

Case 14351—Four Years' Dyspnea in a Boy of Sixteen. *Richard C. Cabot.* Case 14352—Atypical Gall-bladder Symptoms and Their Explanation. *Leland S. McKittrick* 788

EDITORIALS

Antigens and Haptens 792

Laboratory Animals 793

Dr. Coffee Sees It Through 793

The Visiting Surgeons 794

This Week's Issue 794

(Contents continued on next page)

Contents of **Young's Practice of Urology**

VOLUME I

The Physiology and Pathology of Micturition

The Obstructive Uropathy. Lesions Produced in the Urinary Tract by Obstructions to the Pelvis, Ureter, Bladder and Urethra

Urogenital Infections and Infestations: General

Urogenital Infections and Infestations: Tuberculosis

Urogenital Infections and Infestations: Syphilis, Mycoses, and Parasitic Diseases

Urolithiasis

Benign Hypertrophy of the Prostate

Neoplasms of the Urogenital Tract
Kidney and Ureter
Bladder
Urethra
Prostate and Seminal Vesicles
Testis and Other Scrotal Contents
Penis and Scrotum

VOLUME II

Malformations and Abnormalities of the Urogenital Tract

Traumatism and Foreign Bodies of the Urogenital Tract

Ulcerative Lesions of the External Genitalia

Diagnostic Significance of Special Urologic Symptoms

Examination of the Urologic Patient

Operations on the Kidney

Operations on the Ureter

Operations on the Bladder

Operations on the Prostate

Operations on the Seminal Vesicles

Operations on the Scrotum and Scrotal Contents

Operations on the Urethra

Operations on the Penis

Urology in Infancy and Childhood

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CONTENTS

(Continued)

BOOK REVIEWS
The Examination of Patients. Nellis B. Foster.... 802
Modern Practice of Pediatrics. William Palmer Lucas 800

BOSTON MEDICAL LIBRARY
Climatology 795

CORRESPONDENCE
Dr. Pratt Reaffirms His Position. Ezekiel Pratt. 797
Testimony with Respect to Insurance. W. D. Rowland 797

MISCELLANY
Coal-Mine Fatalities in August..... 791
Forthcoming Report on the Saunders Awards..... 797
Medical Tests of Students Compulsory in 42 States. 791
Promotion of Health in Rural Schools..... 791
Resume of Communicable Diseases in Massachusetts—September, 1928..... 796
Weekly Health Index..... 791

NEWS ITEMS..... 798

NOTICES 798

RECENT DEATHS..... 797

NOTICES OF MEETINGS..... 799

SOCIETY MEETINGS..... 799

The Massachusetts Medical Society

The next Annual Meeting of the Massachusetts Medical Society will be held in Boston, June 11 and 12, 1929, "unless otherwise ordered by the Council."

OFFICERS AND STANDING COMMITTEES ELECTED BY THE COUNCIL, JUNE 5, 1928

PRESIDENT: JOHN M. BIRNIE, 14 Chestnut St., Springfield.
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SECRETARY: WALTER L. BURRAGE, 182 Walnut St., Brookline.
TREASURER: ARTHUR K. STONE, Auburn St., Framingham Center.

STANDING COMMITTEES FOR 1928-1929

COMMITTEE OF ARRANGEMENTS
James Hitchcock, E. P. Hayden, H. Q. Gallupe, T. H. Lanman, F. H. Colby.

COMMITTEE ON PUBLICATIONS
Homer Gage, John W. Bartol, R. I. Lee, R. B. Osgood, E. W. Taylor.

COMMITTEE ON MEMBERSHIP AND FINANCE
D. N. Blakely, Algernon Coolidge, Samuel Crowell, Gilman Osgood, Homer Gage.

COMMITTEE ON ETHICS AND DISCIPLINE
David Cheever, W. D. Ruston, S. F. McKeen, Kendall Emerson, A. C. Smith.

COMMITTEE ON MEDICAL EDUCATION AND MEDICAL DIPLOMAS
P. P. Johnson, A. G. Howard, R. L. DeNormandie, H. P. Stevens, C. H. Lawrence.

COMMITTEE ON STATE AND NATIONAL LEGISLATION
J. M. Birnie, A. W. Marsh, T. J. O'Brien, F. E. Jones, Shields Warren.

COMMITTEE ON PUBLIC HEALTH
Dwight O'Hara, E. F. Cody, R. I. Lee, T. F. Kenney, F. G. Curtis.

COMMITTEE ON MALPRACTICE DEFENSE
F. G. Balch, E. D. Gardner, F. B. Sweet, R. P. Watkins, A. W. Allen.

OFFICERS OF THE SECTIONS FOR 1929

ELECTED BY THE SECTIONS

SECTION OF MEDICINE
Chairman, Lester C. Miller, Worcester; *Secretary*, Roger W. Schofield, Worcester.

SECTION OF SURGERY
Chairman, Philemon E. Truesdale, Fall River; *Secretary*, L. S. McKittrick, Boston.

SECTION OF TUBERCULOSIS
Chairman, John B. Hawes, 2nd, Boston; *Secretary*, Walter A. Griffin, Sharon.

SECTION OF PEDIATRICS
Chairman, C. A. Sparrow, Worcester; *Secretary*, Joseph Garland, Boston.

SECTION OF OBSTETRICS AND GYNECOLOGY
Chairman, Frederick L. Good, Boston; *Secretary*, Louis E. Phaneuf, Boston.

SECTION OF RADIOLOGY AND PHYSIOTHERAPY
Chairman, William D. McFee, Haverhill; *Secretary*, P. F. Butler, Boston.

OFFICERS OF THE DISTRICT MEDICAL SOCIETIES

ELECTED BY THE DISTRICT MEDICAL SOCIETIES BETWEEN APRIL 15 AND MAY 15, 1928

BARNSTABLE—*President*, S. M. Beale, Jr., Sandwich; *Vice-President*, H. D. Handy, Harwich; *Secretary*, J. L. Chute, Osterville; *Treasurer*, H. B. Hart, Yarmouthport; *Librarian*, E. E. Hawes, Hyannis.

BERKSHIRE—*President*, C. H. Richardson, Pittsfield; *Vice-President*, M. S. Eisner, Pittsfield; *Secretary*, H. J. Downey, Pittsfield; *Treasurer*, C. T. Leslie, Pittsfield.

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HAMPDEN—*President*, E. P. Bagg, Jr., Holyoke; *Vice-President*, Dudley Carleton, Springfield; *Secretary and Treasurer*, H. L. Smith, Springfield.

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MIDDLESEX SOUTH—*President*, A. W. Dudley, Cambridge; *Vice-President*, Fresenius Van Nüys, Weston; *Secretary*, S. M. Biddle, Cambridge; *Treasurer*, Edward Mellus, Newton.

NORFOLK—*President*, Victor Safford, Jamaica Plain; *Vice-President*, S. F. McKeen, Brookline; *Secretary*, F. S. Cruickshank, Dorchester; *Treasurer*, G. W. Kaan, Reading.

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PLYMOUTH—*President*, T. H. McCarthy, Brockton; *Vice-President*, F. W. Murdock, Brockton; *Secretary and Treasurer*, L. B. Packard, Brockton; *Librarian*, J. H. Weller, State Farm.

SUFFOLK—*President*, Lincoln Davis, Boston; *Vice-President*, W. H Robey, Boston; *Secretary*, A. H. Crosbie, Boston; *Treasurer*, John Rock, Boston.

WORCESTER—*President*, P. H. Cook, Worcester; *Vice-President*, A. M Shattuck, Worcester; *Secretary*, C. A. Sparrow, Worcester; *Treasurer*, G. O. Ward, Worcester; *Librarian*, A. C. Getchell, Worcester.

WORCESTER NORTH—*President*, J. H. Kearney, Fitchburg; *Vice-President*, C. S. Brigham, Leominster; *Secretary*, C. H. Jennings, Fitchburg; *Treasurer*, F. H. Thompson, Jr., Fitchburg.

Fellow Members! We want your support.

The New England
Journal of Medicine

VOLUME 199 OCTOBER 18, 1928 NUMBER 16

The Massachusetts Medical Society

PROCEEDINGS OF THE COUNCIL

OCTOBER 3, 1928

A STATED meeting of the Council was held in John Ware Hall, Boston Medical Library, Wednesday, October 3, 1928, at 12 o'clock, noon. The President, Dr. John M. Birnie, of Springfield, was in the chair, the Vice-President, Dr. Peer P. Johnson, of Beverly was on the platform and the following 135 Councilors present:

BRISTOL NORTH
F. A. Hubbard
J. L. Murphy

BRISTOL SOUTH
G. E. Borden
R. B. Butler
E. F. Cody
D. J. Fennelly
E. D. Gardner
W. A. Nield
I. N. Tilden

ESSEX NORTH
E. S. Bagnall
J. F. Burnham
H. F. Dearborn
A. P. George
T. R. Healy
F. S. Smith
F. W. Snow
L. T. Stokes
W. D. Walker

ESSEX SOUTH
O. S. Pettingill
F. W. Baldwin
E. B. Hallett
W. T. Hopkins
P. P. Johnson
J. F. Jordan
J. W. Trask

FRANKLIN
H. G. Stetson

HAMPDEN
J. M. Birnie
H. D. Gafney
M. S. Hodskins
A. G. Rice
J. P. Schneider

HAMPSHIRE
A. J. Bonneville
L. O. Whitman

MIDDLESEX EAST
C. E. Montague

MIDDLESEX NORTH
J. H. Lambert
J. A. Gage
G. A. Leahey
J. A. Mehan
T. A. Stamas

MIDDLESEX SOUTH
A. W. Dudley
C. F. K. Bean
A. H. Blake
W. T. Burke
W. H. Crosby
F. G. Curtis
Cora E. Harriman
H. J. Keaney
Edward Mellus
C. E. Mongan
J. P. Nelligan
J. W. Sever
E. H. Stevens
A. K. Stone
W. S. Whittemore
H. J. Walcott

NORFOLK
Victor Safford
D. N. Blakely
F. A. Bragg
W. L. Burrage
Samuel Crowell
F. P. Denny
D. G. Eldridge
M. H. A. Evans, Jr.
C. S. Francis
W. A. Griffin
J. B. Hall
H. T. Holland
Joseph Holzman
I. R. Jankelson
G. W. Kaan
W. A. Lane
H. W. Martin
S. F. McKeen
F. S. Schmidt
R. D. Schmidt

NORFOLK SOUTH
D. A. Bruce
C. S. Adams
N. R. Pillsbury
C. A. Sullivan

PLYMOUTH
T. H. McCarthy
J. J. McNamara
C. G. Miles
G. A. Moore
L. B. Packard
J. P. Shaw
A. C. Smith

SUFFOLK
Lincoln Davis
A. E. Austin
J. W. Bartol
Horace Binney
J. L. Bremer
W. J. Brickley
L. T. Brown
David Cheever
A. L. Chute
R. C. Cochrane
F. J. Cotton
A. H. Crosbie
W. P. Cross
R. L. DeNormandie
G. S. Derby
W. H. Ensworth
James Hitchcock
E. P. Joslin
R. I. Lee
J. H. Means
W. S. Parker
Jane D. K. Sabine
G. C. Shattuck
J. J. Skirball
Robert Soutter
J. S. Stone
E. W. Taylor
Conrad Wesselhoeft

WORCESTER
P. H. Cook
W. P. Bowers
L. R. Bragg
G. A. Dix
G. E. Emery
J. J. Goodwin
R. W. Greene
David Harrower
E. L. Hunt
A. G. Hurd
A. W. Marsh
L. C. Miller
C. A. Sparrow
E. H. Trowbridge
R. P. Watkins
F. H. Washburn
S. B. Woodward

WORCESTER NORTH
J. H. Kearney
W. E. Currier
C. H. Jennings
A. F. Lowell

The minutes of the last meeting were read in abstract by the Secretary and as there were no corrections or omissions noted they were accepted as printed and read. The President called attention to the loss the Society had sustained in the death of Andrew Hall Hodgdon, of Dedham, on September 13, 1928, a Councilor since 1923, also an eminent medical examiner of the first Norfolk District after the year 1890; the President spoke of the plans of the standing Committee on State and National Legislation as to legislation in Massachusetts this winter and said that the committee had decided to concentrate on the bill of Dr. S. B. Woodward requiring the vaccination of the pupils of the private schools of the State, a bill which would be reintroduced into the Legislature in January.

Dr. James Hitchcock, Chairman of the standing Committee of Arrangements, read the appended preliminary report of his committee for the annual meeting of the Society next June:

PRELIMINARY REPORT OF COMMITTEE OF ARRANGEMENTS

I have talked with the Copley Plaza Hotel, and the Hotel Statler with regard to caring for our convention in June, 1929. I have assumed that we shall want a three-day convention, and take it that the best days would be June 10th, 11th, and 12th. The Copley Plaza is very glad to reserve these days for us, and the layout which we can use seems to me to be

excellent. The Statler is unable to accommodate the Society on account of previous engagements for those dates.

The general plan for the three-day schedule would be, Monday morning clinics at the Boston hospitals followed by luncheon at the hospitals. Monday afternoon special diagnostic clinics or lectures. Monday evening entertainment. Tuesday morning section meetings. Tuesday noon Cotting lunch. Tuesday afternoon section meetings. Tuesday evening Shattuck lecture. Wednesday morning section meetings. Wednesday noon annual dinner.

Details have in no way been worked out, but we shall try to make the exhibits a real feature of interest to the physicians and so arranged as to be agreeable to the exhibitors. We shall also try to provide on Monday evening an entertainment which will be highly amusing and appropriate for the occasion.

JAMES HITCHCOCK, *Chairman.*

The President called for remarks or suggestions but there were none and the report was accepted by vote.

In the absence of Dr. Homer Gage, Chairman of the standing Committee on Publications, the Secretary announced for him that Dr. W. H. Robey of Boston will deliver the Shattuck Lecture before the annual meeting next June. Dr. D. N. Blakely, Chairman of the standing Committee on Membership and Finance, made the following two reports, on membership and on finance, respectively, and they were accepted and their recommendations adopted by separate votes:

REPORT OF COMMITTEE ON MEMBERSHIP AND FINANCE, ON MEMBERSHIP

Your Committee makes the following recommendations as to membership:

1. That the following named three Fellows be allowed to retire under the provisions of Chapter I, Section 5, of the By-Laws:

1. Amadon, Arthur Frank, Boston.
2. Pope, Frank Fletcher, Ashby.
3. Yenetchi, Henry Ainsworth, Somerville.

2. That the dues of the following named two Fellows be remitted under the provisions of Chapter I, Section 6, of the By-Laws:

1. Lichtenthaeler, Marguerite Emile, Wellesley Hills. (1928.)
2. Stevens, Harold Elmer Ellsworth, Roscoe, California. (1927 and 1928.)

3. That the following named Fellow be allowed to resign, under the provisions of Chapter I, Section 7, of the By-Laws, with remission of dues for 1928:

1. Robb, Hunter, New York City.

4. That the following named six Fellows be deprived of the privileges of fellowship, under the provisions of Chapter I, Section 8, (a) and (b), of the By-Laws:

1. Corea, George Thomas, Provincetown.
2. Doyle, Frank William, Northampton.
3. Elliott, John Lawson, Salem.
4. Morris, James Stewart, Revere.
5. Robbins, George, Boston.
6. Sullivan, Leo Jeremiah, Fall River.

5. That the following named thirteen Fellows be allowed to change their membership from one District Society to another without change of legal residence, under the provisions of Chapter III, Section 3, of the By-Laws:

Five from Middlesex South to Suffolk.

1. Feldman, Louis, Everett.
2. Higgins, Harold Leonard, Newton.
3. Lanman, Thomas Hinckley, Newton.
4. Peck, Martin William, Cambridge.
5. Rogers, Horatio, Newton Center.

One from Norfolk to Essex North.

1. Hall, Llewellyn, Wellesley Hills.

Six from Norfolk to Suffolk.

1. Barton, Frank Eugene, Jr., Brookline.
2. Bigelow, George Hoyt, Milton.
3. Hayden, Edwin Parker, Brookline.
4. Huntington, James Lincoln, Brookline.
5. Ladd, William Edwards, Milton.
6. Sziklas, Charles, Milton.

One from Suffolk to Middlesex South.

1. Pavlo, Samuel George, Malden, reversing transfer of June, 1916.

DAVID N. BLAKELY, *Chairman.*

REPORT OF COMMITTEE ON MEMBERSHIP AND FINANCE, ON FINANCE

Your Committee recommends

That the annual assessment for 1929 be $8.00 for Resident Fellows and $6.00 for Non-Resident Fellows.

DAVID N. BLAKELY, *Chairman.*

The reports of special committees to consider the petitions of T. F. Grady, E. F. Pope and Charles Dudley, for restoration to the privileges of fellowship, were read severally by the Secretary and all were accepted, under the usual conditions. The following petitions to be restored were read by the Secretary and committees appointed, on nomination by the Chair, to consider them:

For Antoinette F. Konikow	J. B. Hawes, 2d W. P. Coues John Rock
For C. L. M. Holmberg	J. H. Drohan G. A. Moore J. F. Callahan
For M. T. Scanlan	W. P. Cross G. P. Morris E. J. Denning
For Mitchell Sisson	T. J. O'Brien Robert Bonney J. D. Taylor

Dr. H. G. Stetson, of Franklin, reported for the delegates of the Massachusetts Medical Society at the annual meeting of the House of Delegates of the American Medical Association at Minneapolis, last June. (See Appendix No. 1.) The report was accepted. In the absence of the chairman of the special committee on Clinics and Health Associations, Dr. W. G. Curtis, the report of this committee was read by Dr. J. F. Callahan, of Brockton. (See Appendix No. 2.) The Chair read the report a second time and asked for any remarks or comments. There were none and the report after being duly seconded was accepted by vote. The Chair read the report of the Committee on a Permanent Home. (See Appendix No. 3.) No action.

Dr. Horace P. Stevens, of Cambridge, read the report of the special committee appointed last June to investigate the Workmen's Com-

pensation Act, particularly in its application to hospitals and hospital staffs. It was a report of progress only and the committee asked for more time. The committee had met and organized and had voted that its first work should be to arrange conferences with the Industrial Accident Board and with various insurance companies, in order to discuss intelligently the problems which have to be met. This matter had been intrusted to a sub-committee of five members. No action.

The Chair nominated and the Council appointed the following committee to Audit the Treasurer's Accounts, as of December 31, 1928: Gerald Blake, Boston, and C. H. Hare, Boston. A vacancy in the committee to co-öperate with the Committee of the Massachusetts Bay Tercentenary, Inc., caused by the death of John Warren was filled by the appointment of W. H. Robey, of Boston, and in the representation of the Massachusetts Medical Society on the Massachusetts Central Health Council, in place of M. V. Safford, resigned, by the appointment of Dwight O'Hara, of Waltham, Chairman of the standing Committee on Public Health.

The Chair called for any incidental business. There being none the Council adjourned at 12.42, noon.

WALTER L. BURRAGE, *Secretary.*

APPENDIX TO THE PROCEEDINGS OF THE COUNCIL

NO. 1

REPORT OF THE DELEGATES TO THE HOUSE OF DELEGATES OF THE AMERICAN MEDICAL ASSOCIATION

As the senior member of the delegates to the House of Delegates of the American Medical Association from the Massachusetts Medical Society I beg leave to submit the following brief report of our attendance at the last session of the Association, held at Minneapolis, June 11 to 15, 1928.

This society was represented by the following delegates: Fred B. Lund, of Boston, Edmond F. Cody, of New Bedford, Roger I. Lee, of Boston, H. G. Stetson, of Greenfield, Charles E. Mongan, of Somerville, and J. Forrest Burnham, of Lawrence. All of these delegates were registered as present and all attended every session of the House of Delegates. Dr. F. B. Lund was appointed a member of the reference committee on medical education, and Dr. C. E. Mongan a member of the reference committee on reports of the Board of Trustees and of the Secretary. Contrary to the custom which I have followed in the past I shall make no formal report or review of the work done but simply call to the attention of the Councilors that a complete record of the transactions of the House of Delegates is published in the *Journal of the American Medical Association* immediately following the meeting and in addition an abbreviated report or digest has since been printed and has been sent to every member of the Association as an issue of the "Bulletin". In view of this publicity it seems useless reduplication to burden your ears with any further report of what was done at this meeting. I think it is but natural that the individual members of the House of Delegates should feel at times that not enough attention and study are given to the printed reports by the individual members of the Association; that criticisms are made sometimes of the actions taken by the House on the problems of public medicine frequently arising that might never have been made if the critics had undertaken a careful study of the facts before they ventured to criticise. In behalf of the delegates from this Society I would urge a more general reading and knowledge of the actual business transactions of the Association as brought out at the annual sessions of the House of Delegates. In closing allow me also to express to the Council on behalf of the delegates our appreciation of the privilege accorded by electing us as the representatives of the Massachusetts Medical Society at this meeting, a privilege not without honor.

H. G. STETSON.

NO. 2

REPORT OF THE COMMITTEE ON CLINICS AND HEALTH ASSOCIATIONS OF THE MASSACHUSETTS MEDICAL SOCIETY

The council meeting at Worcester, June 5, 1928, passed a resolution requesting that the Committee on Clinics and Health Associations call the attention of hospitals to the principle that patients with means to pay should not be allowed the privilege of free bed service. That the soliciting of patients for free beds and clinics is unethical. That pay clinics, where doctors are paid by the day or night, or where there is a division of the fee per patient, is a form of soliciting with fee-splitting which is not tolerated in the practice of medicine by members of the Massachusetts Medical Society.

All the hospitals in the State have been sent copies of these resolutions together with resolutions passed by a joint committee of the State Charities Aid Association of New York and of the Medical Society of the State of New York.

It was suggested that hospitals and district societies appoint committees to discuss these problems that may be present in their districts.

The right of district societies to regulate matters pertaining to free service given by its members is fully recognized by the state society. In the metropolitan district a condition exists that perhaps may call for or invite recommendations or suggestions from the parent society.

Several districts in the metropolitan district are so served by hospitals that there is a passing of patients from one district to another. We have had several complaints that hospitals in one district are interfering with the practice of doctors in adjoining districts. The practice of members so affected is confined largely to the Norfolk, Middlesex South and the Suffolk districts.

To correct certain abuses that have presented themselves in these districts the following resolution is recommended:

Resolved: That a committee consisting of the presidents, vice-presidents and secretaries of the Norfolk, Midlesex South and Suffolk district societies be created. That the committee be authorized to confer with hospital and health associations in these districts in regard to a possible solution, through a code of procedure or otherwise, of the unsolved and vexatious problems which lie in the field of medical practice and its related economics.

NO. 3

REPORT OF THE COMMITTEE ON HEADQUARTERS

Since the last meeting of the Council numerous conferences have been held between representatives of the Boston Medical Library and the Massachusetts Medical Society. All have expressed a willingness to co-öperate in raising funds for the needs of each.

A small committee has been formed to work out definite plans with this end in view. This committee will report to the larger committee of all the representatives in the hope and expectation that an active campaign for the raising of adequate funds may be undertaken at once.

JAMES S. STONE.

BOSTON SURGICAL SOCIETY, INC.

THE PRESENTATION OF THE HENRY JACOB BIGELOW MEDAL

THE Boston Surgical Society met in the Ball Room of the Copley Plaza Hotel, October 10, 1928.

There were present in addition to members of the Society many distinguished surgeons who were participating in the exercises of the Clinical Congress of the American College of Surgeons and local guests.

The meeting was called to order by Dr. William P. Graves, Vice-President of the Boston Surgical Society who addressed the meeting and introduced the special guest of the occasion as follows:

Ladies and Gentlemen:

You are assembled here this evening to join the Boston Surgical Society in paying high honor to a distinguished surgeon.

For the benefit of the many guests here present, who may be unacquainted with our local institutions, it is fitting that I should say a few words in explanation of the nature of the award which we are about to make.

The Boston Surgical Society, as its name implies, is a purely local organization that is devoted primarily to mutual instruction among its members.

But in addition to this, it has a second important function, in that it honors itself by conferring from time to time a gold medal upon some member of the profession in recognition of conspicuous achievements in the broad field of surgical science.

To Dr. George H. Monks belongs the credit, many years ago, of having conceived the idea of such an award, and of attaching to it the name of Henry Jacob Bigelow, one of the great pioneers of modern surgery in America, and one whose memory the profession of Boston never ceases to honor.

Through Dr. Monks's influence a generous sum for the everlasting perpetuation of this medal was donated to the society by the late William Sturgis Bigelow, son of the illustrious surgeon.

It has always been the policy of the society to maintain the highest possible standard in its choice of the recipients of this medal, and I am sure that you will agree that it has been faithful to its purpose.

Amiel in his Journal wisely said, "Doing easily what others find difficult, is talent: doing what is impossible for talent, is genius".

Now our profession contains many men of noble talent who are laboring zealously and well along the paths that have been blazed for them by genius. But the men of genius are few.

To define true greatness in a surgeon would indeed be a complex task, but it is safe to say that it must comprise at least three elemental factors:

First, that of eminent performance, an attribute of talent;

Secondly, the much rarer creative power which opens up new fields of endeavor for the surgical rescue and preservation of human life;

And thirdly and rarest of all, it must include that indefinable greatness of personality, typical of all genius, which irresistibly impresses itself in indelible characters upon the age in which it exists.

It is precisely the combination of these high qualities which the Boston Surgical Society is wont to signalize by the award of its medal.

Only three awards have thus far been made.

The first was given to Dr. William W. Keen whom Dr. Cushing in his presentation speech so happily characterized as a great American surgical institution.

Dr. Keen, now at the patriarchal age of ninety-three, in the full possession of his faculties, must indeed view with deep personal satisfaction the progress of American surgery, in the development of which he has played so important a part ever since the days of the Civil War.

The second award was made to Dr. William J. Mayo, with whose achievements you are all intimately familiar.

In future histories of American Surgery, the names of Dr. Mayo and his famous brother will mark a new epoch of supreme importance in the organization of the surgical clinic.

Dr. Rudolph Matas received the third award of the Bigelow medal.

Dr. Matas from his notable contributions to surgery, particularly that of the circulatory system, his revered personality, and his broad culture occupies in the Southern states a deanship of surgery comparable to that of Dr. Keen in the North.

It is but natural that the Olympian figures of our profession should for the most part appear in the field of general surgery, with its more varied scope for performance, and its wider horizon for the creative imagination.

But in these days of specialization it is inevitable that greatness should crop out in what are called, the minor branches of surgery.

The Boston Surgical Society has this year chosen as the new recipient of its medal a great specialist, one who is not only the foremost figure in his particular branch of surgery but who has the unique distinction of having himself created the specialty of which he is so brilliant an exponent.

Before the formal presentation of the medal, Dr. Jackson will deliver an illustrated address,

entitled "Bronchoscopy, Present, Past, and Future".

I take the greatest pleasure in introducing to you Dr. Chevalier Jackson, Professor of Bronchoscopy and Oesophagoscopy in the Graduate School of the University of Pennsylvania.

To Dr. Harvey Cushing is allotted the honor of presenting the Bigelow medal to Dr. Jackson.

BRONCHOSCOPY; PAST, PRESENT AND FUTURE

BY CHEVALIER JACKSON, M.D., SC.D., LL.D., F.A.C.S.*

BRONCHOSCOPY, strictly speaking, is a procedure using a tube that serves as a speculum for the examination of the interior of the bronchi. The term, however, as now generally used is meant to include the specular examination of the larynx, trachea, esophagus and stomach. This implicative broadening of the scope of the word is justified on the ground that the bronchoscopist indules all the regions in his field of specular examinations, and of convenience because to speak of direct laryngoscopy, tracheoscopy, bronchoscopy, esophagoscopy and gastroscopy, is such a lengthy and cumbersome enumeration that a single convenient word was needed. Common usage has saddled the additional meaning on the word "Bronchoscopy".

Reducing the definition to simple terms for the benefit of the lay members of the audience it may be said that "Bronchoscopy is looking into the living lungs".

A categoric listing of all the past events in the development of bronchoscopy would be out of place on this occasion. Only a broad view of the past development, the present status and the future outlook can be presented here.

THE PAST

Bronchoscopy, strictly speaking, is a development of the last 30 years.

In 1897, Gustav Killian removed a foreign body from a bronchus.

In 1898 the first bronchoscopy worthy of the name was done in the United States. It would please Dr. Henry Jacob Bigelow, if he were present, to know that this was done in the City of Boston, at the Massachusetts General Hospital, by a Professor of the Faculty of Harvard Medical School. It was on May 11, 1898 that Algernon Coolidge, Jr., using an open urethroscope, a head mirror and reflected sunlight, removed through the already present tracheotomic fistula, a portion of a hard-rubber tracheotomic cannula from the right bronchus of a man, aged 22 years.

A distally lighted bronchoscope was developed about 24 years ago and thousands of foreign bodies have since been removed; how many it is impossible to estimate even approximately, because exact and separate records have not been kept by most operators.

In the early days of bronchoscopy the procedure was used almost exclusively for the removal of foreign bodies. External surgery for foreign body in the larger bronchi near the root of the lung was attended by such high mortality that bronchoscopy was welcomed. At that time external surgery was resorted to only at the periphery of the lung and after abscess formation. In those early days bronchoscopy was attended with considerable mortality, but its mortality was much less than that of thoracotomy. Perfection of the technic, the development of team-work, and the elimination of general anesthesia practically eliminated mortality. The solution of the mechanical problems, many of them exceedingly difficult and seemingly impossible, has brought bronchoscopy to such a degree of perfection that 98 per cent. of inspirated foreign bodies may be bronchoscopically removed, through the mouth, with a mortality of but little over one per cent., considering the procedure apart from the condition for which it is done.

When it was found that practically no mortality was attached to the mere insertion of a bronchoscope into the bronchi, the development of its use in pulmonary diseases of other than foreign body origin came rapidly. Many interesting and vitally important discoveries were made with the development of this mechanical means for objective examination of the interior of the tracheobronchial tree. Only a few need be mentioned here.

1. *The Defensive Power of the Lungs:*—Bronchoscopic researches demonstrated that the deeper bronchi were practically sterile, and that the bacteria were increasingly numerous as the larynx was approached. Inasmuch as bacteria-laden atmospheric air necessarily reaches the alveoli the findings justified the inference that the defensive powers of the lung destroyed the bacteria. Two obvious elements in this defensive power are the cough reflex and the ciliary action. The tissues and juices everywhere in the body have defensive powers against bacterial invasion; but the defensive power that bronchoscopic studies have demonstrated is one against bacterial invasion by air-borne infection. Invasions by the hematogenous route do not meet with the same degree of defense. It is by assisting in this defence by the bronchoscopic attack on the invading host from the rear that the marvelous results of bronchoscopic aspiration in early suppurative pulmonary disease seem to be obtained.

2. *Absence of the Cough Reflex:*—It was discovered that under some conditions the cough reflex was nearly or totally absent for a period

*For record and address of author see "This Week's Issue," page 794.

of time, and that this absence of the cough reflex, resulting in stagnation, is an important factor in the etiology of suppurative disease of the lung.

3. *Destroyed Cilia:*—It was demonstrated that cilia are destroyed in certain diseased conditions. Granulation tissue, epithelialized granulomatous and cicatricial tissue, removed from patients with bronchiectasis, pulmonary abscess and suppurative bronchitis, showed absence of cilia in portions of the affected areas. Moore and Moffet showed impairment and destruction of cilia in asthmatic patients.

4. *Legislative Activities:*—The Legislative Hall may seem far removed from the Bronchoscopic Clinic; but no other than the endoscopist had seen the steady stream of pitiable children, unable to swallow food and even water, many of them dying of hunger and thirst, that came to the Bronchoscopic Clinic, because stricture of the œsophagus followed the swallowing of inadequately labelled caustic alkalies sold in all grocery stores for household use. Some of the preparations not only had no "Poison" label, but had a misleading statement as to alleged harmlessness of the particular preparation in the container. An active campaign started by bronchoscopists and laryngologists, and carried out with the aid of Dr. W. C. Woodward, of the Bureau of Legal Medicine of the American Medical Association, and of Dr. Charles W. Richardson, and others, a Federal Caustic Act was enacted. It provides for and has accomplished the labelling of all household lye preparations with the word "Poison". Similar laws have been enacted in 19 states.

It was through the activity of Francis P. Emerson and of those whose aid he excited that one of the very best of these state laws was passed in Massachusetts.

5. *The American Bronchoscopic Society:*—This active organization shows by its transactions a record of the past, an index of the present and a forecast of the future of bronchoscopy and its associated procedures. It now numbers about 50 active members and each year worthy applicants are qualifying for admission.

THE PRESENT

The activities of the Bronchoscopic Clinic of today are concerned but a small part of the time with foreign body word. This is not because the cases of foreign body in the lung are less numerous than formerly; on the contrary, they are increasingly numerous. The disproportion arises from the fact that bronchoscopy, esophagoscopy and gastroscopy are now procedures required of us by the internist and the surgeon for the diagnosis and treatment of disease.

The activities may be listed as follows:

1. Endoscopy for research.
2. Endoscopy for foreign body.
3. Endoscopy for disease.
4. Education of the undergraduate.
5. Education of the graduate.
6. Education of the public in prophylaxis.

Endoscopy in Research:—The mechanical means for the placement of materials, inert as well as infectious, in the lungs and of observing the local as well as the general effects of these materials has opened an enormous field for the study of pulmonary physiology and pathology. The large field for anatomic study of the lymphatic system of the lungs is as yet almost unexplored. The lines of research opened are too many for consideration here.

Physiologic Studies:—The means of harmlessly inspecting the living moving bronchi not only of dogs, but also, in the course of diagnosis and treatment of disease, of human beings, afforded a therebefore unobtainable opportunity for the study of the normal bronchial movements. It was discovered that the bronchi not only expand and contract in inspiration and expiration, respectively; but they elongate and shorten; they bend, twist, and are dinged in. The marvelous resiliency of the tracheobronchial tree was for the first time demonstrated. The endobronchial view was and always will be an awe-inspiring sight. The many contributions to our knowledge of the physiology and the living anatomy will be found in the literature. An enormous field for research remains uninvaded.

ENDOSCOPIES FOR FOREIGN BODIES IN THE AIR AND FOOD PASSAGES

The present status of the foreign body phases of the work shows that endoscopic removal is successful in fully 98 per cent. of the cases. There is no mortality involved in the mere putting down of a bronchoscope, considered apart from the condition for which it is done. Taking the patients as they come, the mortality is less than two per cent.

ENDOSCOPY FOR DISEASE

In the early days of bronchoscopy the work was chiefly upon patients having or suspected of having a foreign body lodged somewhere in the air or food passages.

Today only about two per cent. of the endoscopies are done for foreign body; the other 98 per cent. being for the diagnosis or treatment of disease.

In all diseases of the larynx, trachea, bronchi, pulmonary parenchyma, mediastinum, hypopharynx, esophagus and stomach, direct vision, biopsy and direct therapeutic or operative measures have been added, by endoscopic developments, to the resources of the physician and surgeon in their battle with maladies in these regions. To get an adequate conception of what this means we have only to recall what cystoscopy has done for genito-urinary surgery.

Inasmuch as present limitations prevent the presentation of all that has been accomplished, it seems invidious to mention a few things; and it is very difficult to choose the few; but some mention must be made.

Direct Laryngoscopy:—Never until the development of the direct laryngoscope was it possible to look at the larynx of a baby. Hence it

remained for the direct laryngoscopist to discover that congenital laryngeal stridor may be due to recurrent paralysis, resulting in some cases from forceps traction during accouchement; to papillomata; as well as to rachitic flabbiness of the upper laryngeal aperture.

In adults, the diagnostic information to be obtained is invaluable. For the removal of a benign growth, a vocal nodule, or doing a biopsy the precision afforded has rendered invaluable the direct method of instrumentation under guidance of the eye.

Bronchoscopic Aspiration:—It is probable that the drainage of superficial foci of suppuration was done with a flint in the hands of the caveman. It is reasonably certain that this was done by ancient Peruvian. Hippocrates preached and practiced drainage of pus, and since his time drainage has been fundamental in surgery. Bronchoscopic aspiration is the same in principle; the new thing about it is the discovery that with the bronchoscope suppurative foci can be drained through the mouth harmlessly and without general anesthesia. There is an abundance of clinical evidence at the Bronchoscopic Clinic justifying my opinion *that the fundamental factor in all pulmonary pathology is impaired defensive power of the lung due to impaired drainage and aeration. By bronchoscopic drainage we take the load off the cilia, and restore spontaneous drainage. With the restoration of aeration and spontaneous drainage we re-establish the defensive powers of the lung.* I may be a visionary, but when I see the results obtained by bronchoscopic aspiration early in suppurative disease, massive atelectasis, et cetera, I cannot but feel that the first resort in the future will be not to opiates and other antibechics, but to bronchoscopic aspiration, to restore spontaneous drainage instead of hindering it by the continued administration of drugs that paralyze the cough reflex.

Post-tonsillectomic Pulmonary Suppuration:—The discovery of Charles W. Richardson that pulmonary abscess is a complication to be watched for after tonsillectomy has resulted in saving lives. From the bronchoscopist's point of view these cases can be divided into two groups.

1. Those in which the disease is discovered in its incipiency and is promptly treated. Bronchoscopic aspiration will cure nearly all of these.

2. In this group may be placed all those cases in which valuable time has been lost either in diagnosis or in artificial pneumothorax or other methods of treatment. By this I do not mean to minimize the importance of general medical care. On the contrary, medical management is indispensable; but it is of utmost importance that stagnation be prevented at the incipiency. As elsewhere herein mentioned, there is an abundance of clinical evidence at the Bronchoscopic Clinic to show that nearly all diseases of the lung result from temporarily impaired defensive power of the lung, and that this defensive power is restored when aeration and spontaneous drainage are restored by bronchoscopic aspiration. The clogging of the cilia with thick, tough, gummy pus seems to be a fundamental etiologic factor (Figure shown on the screen). Bronchoscopic aspiration as the treatment of choice in the incipiency of post-tonsillectomic pulmonary suppuration has the endorsement of Willy Meyer, and other eminent thoracic surgeons. The internists, who have seen enough of the work are of similar opinion. Professor McCrae, who has seen so much of bronchoscopic aid in the diagnosis and treatment of pulmonary disease, and who is known for his conservatism, strongly advocates bronchoscopic aspiration in these cases.

Vegetal Bronchitis:—Bronchoscopic studies have revealed the great danger associated with vegetal foreign bodies inspirated into the bronchi. Recognition of the peanut kernel as the cause of a fatal form of septic bronchitis, is second in importance only to the development of bronchoscopic means of its removal. While peanut kernels are most frequent in point of number of cases, any other nut kernels and almost any other vegetal substance is almost equally dangerous, and quite as successfully dealt with bronchoscopically.

Spirochetosis:—The presence of spirochetes in the mouth of many individuals rendered it uncertain, in a given case, whether the finding of spirochetes in the sputum was evidence of spirochetosis of the bronchi. The bronchoscope, by enabling the removal of specimens of secretions from the bronchi, uncontaminated by oral secretions, gives the laboratory report absolute positive and negative value.

Vincent's Infection of the Bronchi:—The presence or absence of Vincent's organisms in the bronchi can be determined with absolute certainty by examination of uncontaminated specimens removed bronchoscopically.

Asthma:—So many patients have come to the Bronchoscopic Clinic with conditions having a superficial symptomatic similarity to asthma that we have an aphorism, "All is not asthma that wheezes". Many supposed asthmatics have been found to have some form of bronchial obstruction, such as a compressive stenosis, bronchial stricture, thick, tough secretion, papillomata, granulomata, goitre, thymic hypertrophy, benign growth, aneurysm, adenopathy, malignant growth, or foreign body. Recurrent paralysis may cause asthmatic breathing as well as stridor, especially in the newborn. Asthma of apparently typical manifestations may be due to tough secretions the bronchoscopic aspiration of which will cure the patient. A wheezing respiration, called the "asthmatoid wheeze" is diagnostic of foreign body in the trachea or bronchi.

Postoperative Massive Collapse:—It was due to the insight of a surgeon, Walter Estell Lee,

that the discovery of the mechanism of this disease was made bronchoscopically. In a serious case of this disease Dr. Lee asked Dr. Gabriel Tucker to do a diagnostic bronchoscopy. The bronchoscope confirmed Dr. Lee's hypothesis that the condition was an atelectasis due to obstruction of a bronchus by thick secretions. Bronchoscopic aspiration of the secretions resulted in prompt expansion of the atelectatic lung. Subsequent similar cases confirmed the findings and established the fact. Further confirmation followed when Dr. Lee took the thick secretions removed by Dr. Louis H. Clerf from the bronchi of a patient, with postoperative atelectasis, to Dr. Gabriel Tucker, who placed it in the right main bronchus of a dog. A typical massive collapse was produced in the dog. Then Dr. Ravdin produced a synthetic preparation of the same viscosity. Dr. Tucker put some of this preparation into the right bronchus of a dog. It produced a typical massive collapse.

The conclusion is justifiable that it is thick, viscid secretion that obstructs the bronchus, producing so-called massive collapse as a postoperative complication.

The question as to what causes the secretions to become viscid is very interesting. Dr. Kolmer examined the pus from some of my patients and found that the coagulation of the pus was due to excess of fibrin. The inference is that an excess of fibrinogen from passive congestion produced excessive viscosity. This experiment shows the aid that can be afforded by the bronchoscope in research.

All of the surgeons in all of the hospitals where we have bronchoscopic clinics call upon the bronchoscopists for aspiration of the viscid secretion in their cases of postoperative massive collapse.

Pneumonia:—One of the early discoveries at the Bronchoscopic Clinic was the fact that pneumonia, as the term is understood by internists, practically never occurs as a complication of foreign body in the lung. Recently Coryllos and Bernbaum have demonstrated that pneumonia is essentially an atelectasis due to obstruction of a bronchus by mucous or purulent exudate, and hence relievable by bronchoscopic aspiration.

EDUCATION OF THE UNDERGRADUATE

The five great medical schools of Philadelphia have chairs or lectureships in bronchoscopy and esophagoscopy. The technic of these procedures is not taught to undergraduates; but they are taught the things connected therewith that every medical practitioner should know, for instance, the symptomatology, diagnosis, prognosis and prophylaxis of foreign bodies in the air and food passages.

TEACHING THE TECHNIC OF PERORAL ENDOSCOPY

Though bronchoscopy and similar peroral endoscopic procedures are essentially specular examinations, they present technical difficulties that far exceed those encountered in examinations with other specula. If a direct laryngoscope is simply inserted with no training in the displacements required to view the larynx no endoscopic view of the larynx will be obtained. Without the preliminary exposure of the larynx to view, the bronchoscope cannot be inserted. If an eosophagoscope is put into the hypopharynx and simply pushed upon, the one place into which it will not go is the esophagus. It would go easily into the mediastinum. Yet the trained physician can endoscopically examine the larynx, trachea, bronchi, esophagus, and stomach, without danger to the patient and without general anesthesia.

For this reason the teaching of these procedures becomes one of the most important tasks of post-graduate medical education today. It is a task rather than a problem, because the methods of doing it have been developed, and have stood a satisfactory test. At the University of Pennsylvania, in the Graduate School of Medicine, peroral endoscopy is systematically taught in as satisfactory a way as seems possible within the limitations naturally imposed by the character of the procedure. The same methods were tested at the Faculté de Médecine, Université de Paris, under the sponsorship of Professor Sébileau and Professor Agrégé Lemaitre, and they met with the approval of these eminent authorities on medical education.

EDUCATION OF THE PUBLIC IN PROPHYLAXIS

One of the earliest discoveries at the Bronchoscopic Clinic was that 85 per cent. of the foreign body cases, and 90 per cent. of the lye-stricture cases, were the result of avoidable accidents; in most cases simply carelessness. This discovery seemed to place upon us an obligation to educate the public in prophylaxis. Lantern slides and moving picture films were prepared, welfare workers, nurses, mothers, schools, teachers, Rotary Clubs, Kiwanis Clubs, as well as the medical profession, were interested in a widespread propaganda of prophylaxis. This activity still continues and is a heavy burden on the time of the personnel as well as on the financial resources of the clinic. Abundant evidence of the efficiency of this prophylactic work has encouraged us to continue the campaign of education of the public in prophylaxis.

THE FUTURE

With the lantern slides and moving pictures I have endeavored to present the Past and the Present.

What of the Future?

In the future, as at present, the internist will tap and look and listen on the outside of the chest, (and it is marvelous what diagnostic information is thus obtained); the roentgenologist will continue to look through the patient; but in a continually increasing proportion of cases, the

surgeon, the internist, and the roentgenologist will ask the bronchoscopist to look inside the patient.

It is most important, I think, that we do not allow the brilliant achievements of Bronchoscopy to blind us to the fact that, to use a homely phrase, "The tail cannot wag the dog." Bronchoscopy is only a very small part of medical science. True, it is a very important part, in its narrow sphere; but nevertheless it is, relatively, a small part in the work of the clinician and the research worker of today. Only by the recognition of this fact can we realize the necessity for the closest co-öperation between the endoscopist and his colleagues in the college, the hospital and the laboratory.

Dr. Cushing then conferred the medal with the following words:

"Merit cannot be made greater by calling it to public notice. Virtue lies in the struggle, not in the prize. And the members of this society are fully aware that in conferring this medal they give prominence to themselves rather than to the object of their attentions. For he, in the natural course of things, will already stand high in the esteem and affection of the profession and be one who seeks no other reward. Nor would he so stand did he not look with modesty upon his attainments, be unconscious of the fact that he is a celebrity, and instinctively shun the light of public acclaim.

"The works of a sculptor or painter or architect endure for posterity to appraise. The art of surgery in which you so excel calls for gifts no less rare, for perseverance and training no less arduous, for craftmanship no less artistic and painstaking. But the material on which the surgeon does his work is like himself in the end perishable, and the fact that here was a man whose manual skill and deftness in his chosen field surpassed that of all others of his time becomes soon a fading memory.

"But the Recording Angel knows how few there be among us who day after day, year on end, sacrifice themselves as you have done to be continuously at the sudden call principally of stricken children who by your unique talent are literally snatched from the very crossing of the river. For one who can thus spectacularly transmute agony and grief to health and happiness, the blessings of patient and parents are recompense enough, and what posterity may say matters little in comparison.

"You have shown in your professional tasks that you possess the hands of a magician; in your extra-professional activities that you have the heart of a philanthrope".

At the conclusion of Dr. Cushing's presentation speech, Dr. Jackson responded expressing in a touching manner the wish that he might exhibit the medal to his mother and other forbears to whom he owed the ability to carry on the work to which he had dedicated his life.

THE TREND IN LEGAL FORMS USED IN ADMITTING PATIENTS TO THE DANVERS STATE HOSPITAL

Resume of 6,749 Discharges Over the Ten-Year Period 1917-1926*

BY NEIL A. DAYTON, M.D.,† AND HELEN H. DOLAN, S.B.†

DURING the year 1927 the Massachusetts State Department of Mental Diseases undertook a survey of the 6,749 discharges at the Danvers State Hospital covering a ten-year period (1917-1926). This material was collected in connection with a survey of all patients in institutions on September 30, 1926. Its purpose was to obtain pertinent facts which would assist in the elaboration of building plans for the new Metropolitan Hospital now under construction. Although data were secured giving a very adequate history of each patient, ranging from the type of legal commitment on which he entered the institution to the cause and form of his discharge, the material is too abundant to incorporate at length into any one article. For that reason the subject of this paper concerns one factor only, the various forms of admission which were used to legalize the hospital residence of these discharged cases.

TYPES OF ADMISSION

Before entering into a discussion of the data on hand, it may be well to identify the various types of admission in use throughout the Massachusetts State Hospital system. These range in length from the Emergency form, (Section 78) Chapter 123 General Laws, covering a three-day period, to the regular commitment (Section 51) which may extend over a period of years. This latter type of commitment requires certification by two qualified physicians as to the insanity of the patient and requires also the signature of a judge of the district or probate court before the legal regular commitment can be made. To be discharged from a Section 51 paper, unless the discharge is by death or by transfer, the sanction of the Superintendent must be given and the patient must have proved himself sufficiently recovered to again take his place in the community.

Perhaps the most commonly used shorter type of admission is the Section 79 paper which requires no court action and holds the individual for a period not to exceed ten days. During this time he is observed, an attempt being made to determine the seriousness of his mental disorder and whether or not further treatment is necessary.

Another short form is the Observation Commitment (Sec. 77) which detains the patient for a period of thirty-five days. At the end of this period the Superintendent notifies the judge as to the patient's condition and the patient is then either discharged or he is regularly committed for an indefinite period (R. C. 77). During this entire procedure the patient remains in the institution, being held on a new paper as the time limit expires on each previous form of admission.

There is also a voluntary admission (Section 86) by which a person may make written application for treatment, providing that he is mentally competent to do so. If at any time during his hospital residence he decides to leave the institution, he is required to signify his intention in writing and cannot be detained for more than three days thereafter.

COMBINATION OF TYPES OF ADMISSION

The various forms of admission may be, and very frequently are, used in combination through the change of legal status procedure. Perhaps the most frequent combination is that of Section 79 with Section 51—the temporary care admission and the regular commitment. During the temporary care period, while the patient is under supervision at the hospital, sufficient time is allowed for physicians to determine the nature of his psychosis and whether or not he shall have further hospital treatment. In the latter event additional legal papers are secured, making permanent residence mandatory. Thus, a change of legal status is effected and the patient is transferred from a temporary care to a regular commitment, without having left the hospital.

Another combination that is frequently used is the Observation, Section 77, and Regular Commitment, Section 77. As a matter of fact, practically all the types of admission may be used in combination with one another. If the person enters an institution on a regular court commitment (Section 51), however, this is final and usually precludes any further change of legal status.

In addition to the above, the following are a few of the types of admission which are used together, although they have not occurred often enough in our ten-year study to be considered in detail: Voluntary 86 with Regular Commitment 51; Temporary Care 79, Voluntary 86, and Regular Commitment 51; Temporary Care 79, Emergency 78 and Regular Commitment 51; Temporary Care 79, Observation 77 and Voluntary 86.

*Massachusetts Department of Mental Diseases. Statistical Research Project No. 2. Article 1. Subsequent to July 1, 1928, this project has been subsidized by a grant from the Laura Spellman Rockefeller Fund.

†For record and address of author see "This Week's Issue," page 794.

FREQUENCY OF TYPES USED AT DANVERS

Table I outlines the frequency of types of admission involved in the 6,749 discharges. By far the greater proportion of these entered on regular commitment, Section 51, papers (3,955 or 59.1%). There has been a tendency over the ten-year period for this type of court commitment to decline, however. As shown in Table I, the numbers decreased from a total of 558 regular commitments in the 1917 discharges to 304 in the 1926 discharges.

The second highest proportion of discharges entered Danvers on temporary care papers, (1,678 or 24.8%) and were later transferred to regular commitments, that is, temporary care, Section 79 and regular commitment, Section 51. These forms, when used in combination, show a slight increase from 144 in 1917 to 202 in 1926.

Although only 312 (4.6%) of all discharges entered the institution on temporary care, Section 79, papers, this type of admission stands third in the order of frequency. Its increase has been steady over the ten-year period, as Table I demonstrates. Of the 1917 discharges thirteen patients entered Danvers on temporary care papers, but by 1926 this number had increased to 67.

Admissions on Section 86, Voluntary papers, are fourth in order of frequency, (163 or 2.4%). It is interesting to note the rapidity with which this form has declined in use between 1917 and 1926. Of the total number of discharges from Danvers in 1917 and 1918, 29 and 40 respectively came as voluntary patients. Of the total discharges in 1926, (674) only 1 patient entered on voluntary papers.

Both the Observation 77 alone and the combination of Observation with regular commitment Section 77 have increased in use over the ten-year period, as shown in Columns 5 and 6 of Table I. The increase in both has been gradual but steady. Observation 77 alone rose from but one admission of this type in 1917 to 29 in 1926. Observation 77 and R.C. 77 showed an increase from 2 to 36 during the 10 years.

Graph A shows the trend in the use of these various types of admission arranged according to five-year moving averages. The gradual decrease in the use of the regular commitment, Section 51 is demonstrated here. It is possible that the Observation 77 admission (thirty-five day paper) is superseding this form, for during the ten-year period admissions of this type increased tremendously. Admissions for temporary case (Section 79) likewise showed a rapid increase.

The fact that the use of these two forms (Sections 77 and 79) has become more frequent over the ten-year period is no indication that admissions in general are showing more than a slight increase, however. Many admissions which were formerly under Section 51 have very likely become absorbed in these shorter forms, which suf-

TABLE I

Percent Distribution of the Most Common Legal Forms of Admission.*

Arranged According to Frequency of Section Numbers Used

Danvers State Hospital Discharges

1917 - 1926

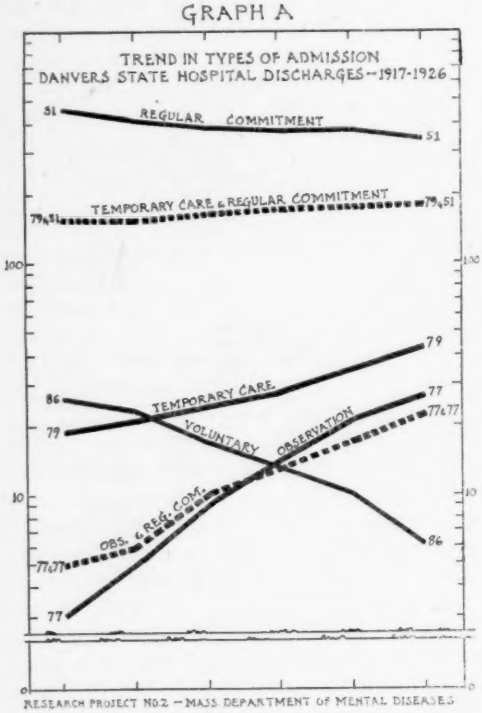
	Section 51 Regular Commitment		Sections 79&51 Temporary Care and Regular Commitment		Section 79 Temporary Care		Section 86 Voluntary		Section 77 Observation		Sections 77&77 Observation and Regular Commitment		Totals All Forms
Year	No.	Percent	No.	Percent	No.	Percent	No.	Percent	No.	Percent	No.	Percent	
1917	556	70.7	144	18.2	13	1.6	29	3.7	1	.12	2	.25	789
1918	444	67.2	121	18.3	10	1.5	40	6.	2	.34	1	.15	660
1919	467	64.5	159	21.8	25	3.4	25	3.4	2	.27	1	.13	723
1920	345	59.4	167	28.7	18	3.1	18	3.1	8	1.3	6	1.0	581
1921	456	62.0	184	24.9	29	3.9	20	2.7	6	.81	15	2.03	738
1922	352	62.0	143	25.1	26	4.6	12	2.1	11	1.9	7	1.2	568
1923	317	52.0	181	29.8	26	4.3	14	2.3	21	3.4	22	3.6	607
1924	384	55.0	191	27.4	39	5.6	3	.43	27	3.8	17	2.4	696
1925	368	51.5	186	26.0	59	8.3	1	.14	43	6.0	28	3.9	713
1926	304	45.0	202	29.9	67	9.9	1	.14	29	4.3	37	5.4	674
TOTALS	3995	59.1	1678	24.8	312	4.6	163	2.4	150	2.2	136	2.0	6749

*Only the five most common forms of admission are shown in this table. The others have been omitted because of their comparative lack of importance.

Under Section 51 Regular Commitment the number for 1925 should be 368.

fice when it is found unnecessary to detain the patient in the hospital after a short period of observation. That is, those types of admission which have decreased in use, as shown in Graph A, are counterbalanced by those which have increased in use during the 10-year period. The

GRAPH A



use of regular commitment, Section 51, and voluntary, Section 86 has decreased over the ten-year period, but this decrease has been more than balanced by increases in temporary care, Section 79, Observation, Section 77, and the combinations of temporary care Section 79 with regular commitment Section 51, and observation Section 77 with regular commitment 77. Inasmuch as the number of admissions for each year to Danvers has shown only a slight increase during the ten-year interval, the increase in certain of the forms used does not indicate any marked increase in the number of admissions to the institution.

SUMMARY

Regular commitment, Section 51 predominates over all other types in the frequency of its use as a legal form of admission (59.1%). Next in order of frequency come the combinations of Temporary Care—Section 79 with Regular Commitment—Section 51 (24.8%); Temporary Care—Section 79 (4.6%); Voluntary—Section 86 (2.4%); Observation—Section 77 (2.2%); and the combination of Observation with Regular Commitment—Section 77 (2.0%).

It must be remembered that we are dealing with discharges and not admissions. Some of the admission dates extend back over many years. We have found, however, that approximately 75% of the patients remained at the Danvers State Hospital less than two years. Thus, the types of admissions on these discharges do not vary greatly from the types of commitment for admissions covering the same period of years.

Although over the ten-year period the regular commitment and voluntary admissions have decreased, it is likely that the great increase of short term admissions, Temporary Care, Section 79 and Observation, Section 77, has balanced the totals.

The short forms of admission which hold a patient but a few days were primarily created for use in cases of an emergency when court action would be too long in process. There seems to be an increased tendency to use these shorter forms in admitting patients even when the emergencies for which they were created do not exist.

FISTULA AN ETIOLOGIC FACTOR IN RECTAL CARCINOMA

BY S. M. FITCHET, M.D.*

CANCER of the rectum is frequently met with on the surgical services of the larger hospitals and is not infrequently encountered in private practice. Russell[1] estimates that about 80 per cent. of intestinal cancers involve the rectum, basing this figure on the work of Gant, Ball, and Halstead. Next to the stomach the rectum is the most common site of cancer of the gastro-intestinal tract. Dewis[2], in his admirable study and review of adenocarcinoma of the duodenum, states that nearly half of all carcinomata are found in the gastro-intestinal tract.

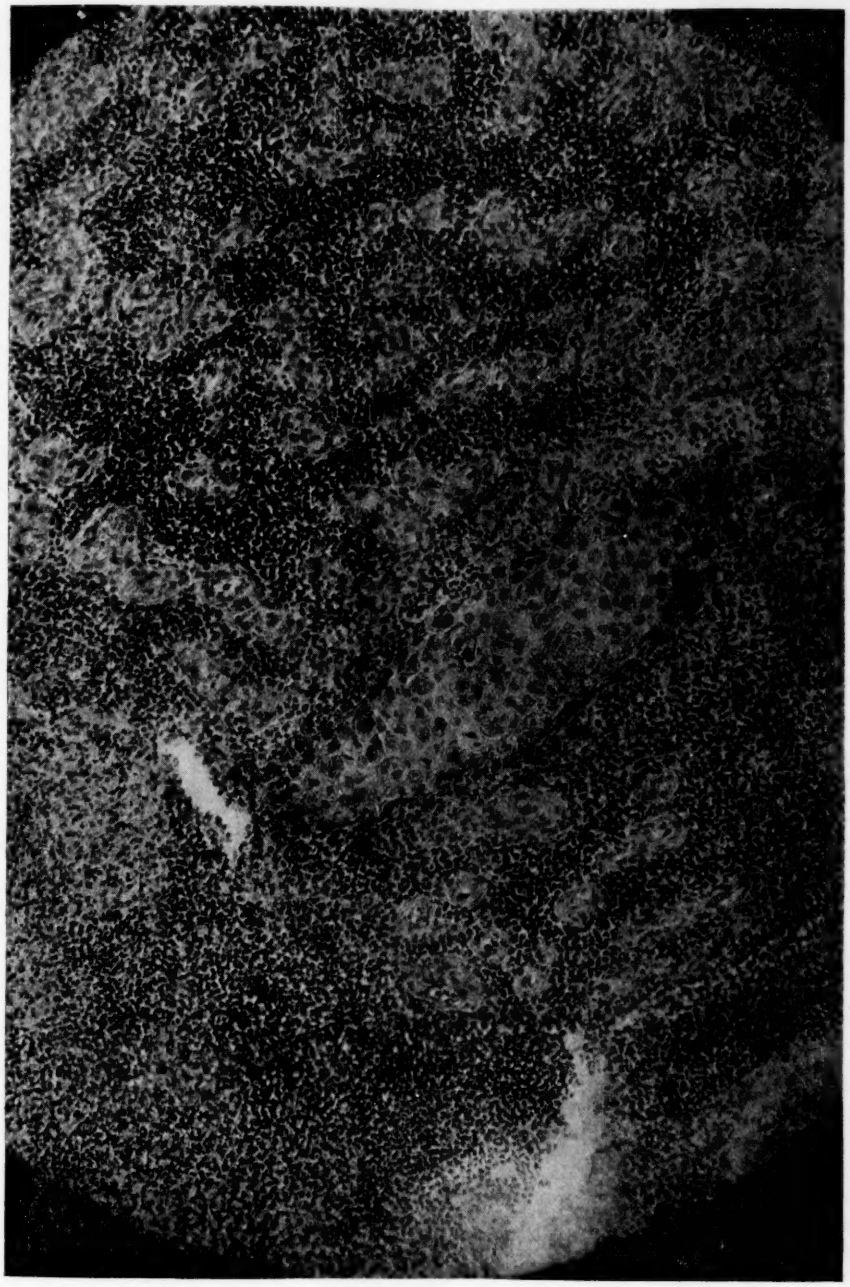
From all the mass of literature concerning cancer we must conclude with Greenough[3] that "no specific cause or remedy for the disease has as yet been discovered." Yet we do know something of its etiology. Greenough points out that cancer can be produced in man and in animals by chemical, physical, and organic agents. He feels that long continued, but not lethal, damage to the tissue cells exposed to an irritant agent is the common factor in artificially produced cancer. He points out, too, that the long continued attempt to repair damaged tissue,—a normal body function,—appears to be involved in all of the so-called "pre-cancerous" proliferations, and only after a sustained effort at this normal process is the arbitrary border-line of cancer passed.

The weight of evidence seems to point to an abnormal degree of growth by previously normal body cells as the important etiological factor, rather than a specific organism. Any evidence that may aid in the determination of the etiology of cancer should therefore be made available.

A form of chronic irritation very frequently

*For record and address of author see "This Week's Issue," page 794.

seen is fistula in ano. Fistulae have from time to time been mentioned as possible factors, because of their chronicity, but have not been seriously considered. Kraske, quoted by Ewing[4], states that there is no satisfactory evidence that cancer develops in tissues altered by fistulae or hemorrhoids.



Fistulae frequently originate inside the sphincters, or mid-rectum. A large number, perhaps 50 or 60%, of rectal cancers are in the mid-rectum. It seems worthwhile, therefore, to publish the following pathological report of one of my cases of carcinoma of the rectum in a woman who had had fistula in ano for about 20 years. This pathological report and photomicrograph are published through the kindness of Doctor Lawrence Weld Smith:

Specimen consists of the lower end of the rectum and the perianal tissues together with the subcutaneous tissues. Surrounding the anus the skin is thrown up into coarse papillary folds, due to the presence of a carcinomatous growth. This growth also extends up into the lower end of the rectum along the mucosa. The growth measures about 4 cm. in length and on section measures 2½ cm. in thickness. It is pinkish white in color, covered over on its free surface with mucosa and on section the surface is rather smooth and homogeneous. It is seen to be invading the subcutaneous tissues and the

tissues of the submucosa. Grossly it appears like a primary squamous cell carcinoma.

Microscopic examination: The sections microscopically present a typical picture of squamous cell carcinoma of about grade No. 2 malignancy. It is seen to be invading the surrounding tissues. The tumor apparently had its origin at the muco-cutaneous border, causing variegated appearance of the tumor cells, ranging from small flattened, almost spindle cells, to large multipolynucleated cells. Numerous mitotic figures are seen.

The tumor is in direct continuity with the epithelial down growth lining a small fistulous tract. This extends several mm. into the subcutaneous tissue. Around this fistula is found a marked inflammatory reaction consisting of polymorphonuclears and lymphocytes. It is accompanied by dense fibroblastic proliferation.

The general arrangement of the histology strongly suggests the chronic inflammatory fistulous lesion as being the chief etiologic factor in the development of the tumor.

Diagnosis: Squamous cell carcinoma; grade No. 2 malignancy; acute and chronic inflammation.

A copy of this report together with the photomicrograph was sent to Professor James Ewing of Cornell Medical School for comment. In a personal communication to me Professor Ewing states that he accepts the diagnosis and adds that he thinks it must be a very rare case, although he sees no reason why carcinoma should not develop on such chronic inflammation as fistula in ano.

Hirschman and Rosenblatt[5] have very recently reported a case of colloid carcinoma developing, apparently, on a typical hemorrhoidal mass. They produce evidence to show that this hemorrhoidal condition, this chronic disease and irritation, had been present for seventeen years, with prolapse of the hemorrhoid for the five years preceding operation.

Here, then, are two cases of rectal carcinoma developing on chronic inflammation; one a fistula in ano of twenty years duration, the second a hemorrhoid of seventeen years duration. It would seem, therefore, that chronic inflammation and disease in and about the rectum and anal ring should be given most serious consideration by the attending surgeon since it may very well be the site of future malignancy.

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NURSING AND MATERNAL WELFARE*

BY STEPHEN RUSHMORE, M.D.†

AS we look back over the past sixty or seventy years in the history of nursing, it seems hardly an exaggeration to say that a new profession has been created. Think of the changes that have taken place since the Crimean War! I was going to say, think of how Florence Nightingale would feel if she were translated to America in 1928, but she lived long enough to see great changes in nursing, and she looked far enough into the future to see things which had not come to pass at the time of her death. I might say, think of how one of her first nurses would feel, who had seen only the early work of Florence Nightingale and who did not live to see it grow. But it will be better for our purpose to think of some lay person, because we can attribute to the Victorian layman of 1850, for example, any amount of ignorance necessary to make our illustration effective. Picture, then, to yourselves, the astonishment, even the consternation of such a person, well meaning and well endowed and well entrenched in tradition, whose motto is "Woman's place is in the Home", if confronted with what the trained nurse does in the United States today! There is bedside nursing of the acutely sick, in the hospital and in the home, with all the changes made necessary by seventy-five years of progress in medicine. There is nursing of the chronic sick, with all the complicated procedures demanded by the special conditions which are involved, resulting almost in specialties in nursing; as in the care of mental deviations from normal, in arthritis, tuberculosis, in the after-care of poliomyelitis.

Then there is public health nursing in home and school, in factory and business, in urban and suburban and rural communities. Progress in public health is so much a matter of public enlightenment, of the development of hygiene, of health habits, of education, that we naturally resort to the methods of mass education of which we are so proud, the radio and the newspaper and the health demonstration. But experience has taught us that the most effective way of teaching is also the most primitive, one pupil, one teacher,—the public health nurse in the home, sitting down and talking with the mother of the family. In fact, nothing else can be compared with this method for effectiveness.

Now those who nurse must be taught their profession and the whole scheme must be administered. The two fields of administration and education give opportunity for the highest talents and we have training schools of many sorts, culminating in what we are pleased to call University Schools of Nursing.

If one regards nursing as a work of architecture, the building is far from complete today. But in value it is indispensable in our modern

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†For record and address of author see "This Week's Issue," page 794.

civilization. It has also much beauty in design and construction. It is imposing in its magnitude. You will find it described in far better words than I can hope to repeat, in the writings of some of those who have helped to lay the foundation and have participated in the building. But are the foundations sure? Will they support the enormous superstructure that is still rising before our eyes?

I am convinced that the foundation is adequate, but as I read about nursing and as I listen to discussion, I often miss reference to one of the essential stones in the foundation, the very cornerstone in fact, on which the whole structture rests. The cornerstone is there, it was placed there in the building and it will remain there, and it must not be forgotten in our thinking. This cornerstone is the proper relation of the nursing profession to the medical profession. What this is I shall note in a moment. But there has been desired by some students of nursing an independent School of Nursing in the University, on the same basis as the School of Medicine and the School of Law. This ambition may be praiseworthy, in so far as it aims at financial independence, but it is important to remember that the work of the nurse is not independent of the physician as it is independent of the lawyer. In fact, the work of the nurse, in so far as she is nurse, is done explicitly or implicitly under the direction of the physician, and it is the physician who carries the chief responsibility. Of course, in the day's work, the nurse may act as purveyor for the family, disciplinarian for the children, nutritionist, visiting housekeeper, social worker, mental healer, in fact be like Kim, a friend of all the world. And outside her nursing she may stuff the ballot box, bootleg, put in practice her own ideas as to the proper length or brevity of her hair and her skirts, and for these the physician does not have to bear responsibility. But does the nurse do anything the physician might not appropriately do? For the nurse, though not practicing medicine under the law, in performing, at the direction of the physician, certain specific acts which would be illegal if performed not under his direction, is just as truly, though in a limited way, practicing the art of healing. The fact that in the division of labor, the nurse can do her work very much better than the physician could do it for her, and that we might well smile to see the ordinary physician trying to do some routine nursing for twenty-four hours does not alter the principle.

And it is this that gives the peculiar relation of nursing to medicine. For nursing is a profession and though the nurse works for a wage, the exchange does not partake of the nature of a trade. For the spirit of trade is to get all one can and give as little as one has to, and the nature of barter is to deceive. But the spirit of a profession is to give for the recompense, whatever that may be agreed upon to be, the best one is able to give, according to the demands of the situation.

I have dwelt at length on this point, because I think I have noticed a little feeling of resentment between the two professions, almost as though there were rivalry. But as I see it, in the future the nurse will become more and more important, and especially in the field of maternal welfare, of which I shall speak in a few minutes, physicians may look for more assistance in caring for patients.

So that my first word is a word of caution that, while we may think of a school of nursing in a university as having a share in the university funds that does not vary inversely with the demands of the medical school, or any other demands of the medical school, or any other department, on the funds of the university, and while we may thus speak of financial independence for the school of nursing, we must not conceive of the function of the nurse as being independent of the function of the physician.

Who shall become a nurse fitted to take advantage of these opportunities and how shall the nurse be trained? I shall say nothing of the selection of candidates, but pass at once to the problem of the training. What kind of procedure is the training of the nurse? Is it education? Is it vocational training? Is it a form of hospital economy? If I were to ask, is it *merely* education, whatever that may mean, or *merely* vocational training, or *merely* a form of hospital administrative economy, it might serve to bring out some of our absurdities in practice. And yet we cannot get away from the fact that, whatever else it may be, it is undoubtedly a form of hospital administrative economy. What has disturbed us in the past and still disturbs us in the present is that this interest has undue influence in control.

Certainly the procedure is vocational training, for the nurse is to earn her living by practicing what she is taught, and is to work for a wage. But the view is becoming more wide-spread that mere vocational training in any field is an unjustifiable limitation and that it always involves wider implications; it should be educational in scope and character.

What is education and what does it imply? Education is an adventure of the whole individual, an adventure and discipline of the human spirit, as well as training of the mind and of the body. This is why we cannot have mere vocational training, no matter how hard we may try; so-called mere vocational training is, in fact, an educational procedure which is perverted, warped and deformed.

The only aspect of education that I desire to emphasize at this time is but one among many, I acknowledge, but it is one we are inclined to neglect or to ignore intentionally, for reasons it is not necessary to discuss now. But among all the other things that education may be, we must not forget that it is essentially religious. For

religion involves two fundamental ideas—it springs from the feeling of awe and reverence; and it finds its completeness in adding to reverence, duty. For how can one spend two years in the hospital nursing the sick, in the midst of pain and suffering and familiar with death, in contact with sordidness and evil, every day seeing diseased bodies and broken lives, handling these very fragments, as it were, of human beings, and, in spite of it all, not become aware of what it is that gives dignity and worth to humanity? And duty, the responsibility of each one of us for doing the best that we can, takes on a new meaning with the consciousness of growth of power that education gives.

Here is emphasized again the old contrast and comparison between the life of contemplation and the life of action, which combined make the perfect life. You may remember the Rule of St. Benedict, which added to the older monastic rules this injunction, that one should labor with one's hand seven hours a day. The time for his Rule, as he gave it, has long gone by, but with that which was temporary and has passed away, he combined the enduring principles of practicality and prayer.

If the training school is an educational institution, does its maintenance fall within the proper function of the hospital? Is this what hospital funds are for? In practice this is just what hospitals have to do, and I shall not discuss this aspect of the question further than to say that every training school ought to have on its committee of management at least the following representatives: There should be a trustee of the hospital to view the situation as a whole. There should be other representatives whose major interests are respectively hospital administration, practice of medicine, nursing and education. Co-öperation in such a group would go far in solving the problems confronting the hospital training schools.

Recognizing the training school as an educational institution and that it is, in actuality, in a condition of transition, with the deplorable but necessary amount of confusion incident to moving day, another question we may ask of it is, what is the training school to become? Of late we have heard that the University School of Nursing is the goal. But of course no one imagines that it is the goal for all schools. There are, and always will be, too many schools, widely separated, and not enough universities for this. But what is a University School of Nursing?

Well, what is a university? On this point we are not quite clear in America today. In Baltimore in 1876, there was founded Johns Hopkins University. It was a new embodiment of certain ideas and ideals of university life which proved a great stimulus to university education in this country. In accomplishment it may well be that other institutions have since surpassed the first American model of 1876. But the ideals have not been outgrown. Even at Johns Hopkins there must have been a feeling that they had fallen away from their original plan, for in recent years a strong effort has been made to rid the institution of some of the impediments to university life, and now actual procedures are in operation directed to this end. We are coming to realize that investigation, research and education in and for this field constitute the prime object of university existence.

If this view is sound, the university school of nursing has its place, for research in nursing is needed as in any other field of human interest. But it should be a graduate school for those who are qualified and desire to study nursing with the scientific method of controlled experiment. At the present time the aggregate mass of nursing is enormous, and the relief to the sick is correspondingly great, but how much of it is carried on under conditions such that the student of nursing,—I do not mean the pupil in the training school,—the student of nursing, can say: "Here is an experiment carried on under such conditions of control as may reasonably be expected in a social experiment of this character; these are the results; and the following trustworthy conclusions may be drawn". At present we are wasting wonderful opportunities in this field.

From what I have said it ought also to be clear that the university school of nursing should be the goal of no school that gives a basic course in training pupil nurses, for that is, strictly speaking, not university work, any more than it is university work to maintain a junior college, except as a defense mechanism. I am aware that we sometimes use the word university as if it were synonymous with universe, when our discrimination fails.

There is another question to which I shall not try to give an answer now, as to whether experience in practical nursing should entitle one to academic credits. It is not a question of the educational value of the experience. It may prove a liberal education of far greater value than the experience with books for which academic credits are usually given. But is this experience of the intellectual nature that academic credits are supposed to represent?

Maternal welfare has always been a matter of great importance for the welfare of the human race, but it aroused new interest during the Great War. For then it became evident that when nations fight one against another, it is not simply armies that fight but whole peoples. And so every individual in the state becomes of potential value for the survival of the state. The war proved in many ways to be a powerful socializing agency, bringing into co-öperation for the good of the state elements otherwise discordant, organizing social activities all over the country, and tending to suppress individual variations from the commonly accepted standards. But it ruthlessly destroyed multitudes

of individuals in the interest of the state, and powerfully increased and stimulated many forces in society which are antisocial and which especially tend to undermine the fundamental social unit, the family, and tend to destroy the home.

These individualistic tendencies, we all feel strongly within ourselves. We *will* lead our own lives. We will *not* be bound by the customs of the past, nor by the opinions of the present. We will *not* be shut in by the obtrusive personalities around us. We will *not* brook interference. We *will* be ourselves and strive for and attain the thing we ourselves want.

There has come down to us through the centuries an influence tending to make us have regard for the infinite worth of the individual, but instead of working out to an intolerable egotism, it has brought society to make greater and greater effort to salvage, "at infinite cost, which is infinite loss", the handicapped in life's battle. And this is done, not for reasons of state, but because of some strange worth of each individual. So we no longer expose on the hillside to the hostile elements the infant that does not happen to meet some external standard of efficiency.

We have not as yet reached a satisfactory practical reconciliation of these two antagonistic forces of individualism and socialism, and never shall, I suppose, for they represent permanent tendencies in human nature, and each new generation and each new individual must strive to find its own reconciliation. But the beginning of the reconciliation is in the home, for we dimly apprehend that the individual must find his highest good in the welfare of the group and the group its highest good in the welfare of the individuals in that group.

Do not think that I have an unduly exalted idea of the part the nurse is to play because I have related her work to this larger social movement. By no means. But I speak of it in this way to indicate to you, if I may, something of the significance of what the nurse may be doing. For however little may be that which each one of us does, or even all of us together, by way of accomplishment, it does help us if we can see what we are doing in relation to larger issues, to the greater movements in the society in which we live. And our civilization today in America needs a new vision of the true value of the home. For we are to look upon the home not as a convenient social institution but as the nursery for souls.

From the point of view of health, maternal welfare is best conserved and promoted if the patient consults a physician as soon as she suspects conception has occurred. The physician should see the patient (a normal case for example) at appropriate intervals and make examinations adequate to determine as well as may be the condition of the patient. If any deviation from normal occurs, he should take steps to bring the patient into a normal condition, and appropriate remedial measures should supplement this supervision and care throughout pregnancy.

I will not take the time to attempt to describe now what is considered a standard procedure in caring for the patient in the prenatal period, at confinement, and in the puerperium, for formal prenatal care is even to the medical profession relatively new, and it represents a relatively unexplored field which we confidently expect will yield rich returns when it is cultivated systematically. I realize that as yet adequate proof is not forthcoming that prenatal care will materially decrease maternal and infant mortality. But the argument is sound and carries the conviction of great probability, and is supported by such statistical evidence as is available. When one sees in relatively small groups of cases in certain clinics a marked diminution of the number and especially in the severity of the toxaemias of pregnancy, and in controlled groups, the almost complete elimination of the dread disease, eclampsia, one cannot escape the conviction that prenatal care ought to be given a greater opportunity to show what it can do.

But if one goes over in one's mind all that the physician may do, and all that a competent nurse may do, in co-öperation, in visiting the patient at her home, sitting down with her, seeing her in the environment in which she lives, counselling and advising her, making certain routine examinations and reporting the results to the physician, one sees that the educational opportunities in teaching the personal hygiene of pregnancy in preparation for childbirth and the responsibilities of motherhood are far greater for the nurse than for the physician. I am making now no reference to the treatment of actual deviations from normal. And the whole teaching of the nurse is given special point in the presence of pregnancy, because to the normal woman anything that affects her unborn baby is of the utmost importance. Of these great opportunities we have scarcely begun to take advantage. Here indeed the primitive method of one pupil and one teacher sitting down together and talking it over surpasses in effectiveness anything devised in later times.

And what shall the nurse teach? I do not mean simply by word of mouth, repeating what she has read in a pamphlet of directions to expectant mothers, but I mean what shall she teach sympathetically and with sincerity and with conviction?

First, that childbearing is for most women a normal physiological function, and that the reasonable expectation is that the particular patient whom the nurse is counselling, and her baby, will be all right.

Second, that what happens in normal pregnancy, from the point of view of health, is that the mother's reserve strength is partly used up. I think this is as good a way as any to express what happens.

Third, that because of this partial using up of her strength, the patient may expect to have during pregnancy many unusual sensations and some discomfort, and that these unusual sensations and the discomfort may be, but generally are not, early signs of her using up too much strength.

Fourth, that most of the troubles connected with pregnancy are preventable.

Fifth, the patient ought to consult a physician regularly because he is in a better position than any one else to find out if those feelings really mean the beginning of some trouble, and if they do, he is in the best position to check the trouble before it becomes serious.

Sixth, that if she takes good care of herself she will be doing the best thing for the baby.

Seventh, that while the relation of mother to child contains the possibility of physical, mental and spiritual anguish beyond any other human relationship, it contains also the possibility of abiding satisfaction and deepest joy. As one of the men of our Southland has said, "Perhaps the supreme distinction of all life is motherhood".

I do not mean, of course, that the nurse should use the words that I have used, but these ideas should be the background of her ministration whatever specific form they may take, and I look forward to the time when in every stratum of society the nurse will have a very much larger place than at present in assisting the physician in promoting maternal welfare.

I must say a word about the midwife, but only a word. We should regard the midwife as a compromise, perhaps necessary under certain existing conditions, but still a compromise, and so a temporary expedient. So important is the life of each individual that every confinement should be supervised and attended by a qualified physician. And while we should, I think, do everything possible to eliminate the midwife, it should not be by mere legal enactments, but by removing also those other conditions under which the midwife maintains herself.

The so-called nursing-midwife is another compromise. I am aware of the excellent, even beautiful work, done by the nursing-midwife in this State. Nevertheless the best that can be said for the system is that it meets certain situations better than any other scheme now available. But its limitations also are apparent, and the situations, though acute and wide spread, are not numerically of such magnitude as to warrant its general adoption.

In what I have said I have so far as possible avoided the discussion of specific procedures and considered chiefly points of view. But there is one practical scheme I would like to suggest for the better training of nurses in obstetrics. It was worked out in Boston[1] under the stress of wartime conditions and had as its main object the better care of women at confinement in their homes. The better training of the nurse was incidental to this purpose. The emergency passed before the scheme was put into operation and it has not been employed elsewhere so far as I know.

The scheme was devised after experience with that employed in training medical students, which with proper supervision, has proved so successful. The scheme involves a hospital with in-patient maternity service, interne, and visiting physician; and a district in which patients are cared for at confinement in their homes.

When the call comes to the hospital saying that the patient is in labor, two nurses, one relatively experienced in obstetrical nursing, preferably a graduate, the other relatively inexperienced, go at once to the patient's home. The necessary external examinations are made, word is sent to the hospital, and the patient and her home are prepared for the delivery. The interne comes from the hospital for the delivery and at least one nurse is with the patient constantly until she is finally left after delivery.

The scheme is applicable in certain communities and has the following advantages: It increases the amount of obstetrical experience available for nurses and thereby improves their training. It gives them supervised experience in the home, very desirable and now generally lacking. Delivery of patients by the nurse under the supervision of the physician might occasionally prove practicable. It vastly improves the care at confinement for certain women in the community.

The cost, as estimated originally, even allowing liberally for prompt transportation of nurses and physicians, was not excessive and was very much less than the cost of caring for the patient by hospitalization. By improving the care in the home, the expensive hospital beds may be utilized more economically for patients in urgent need of hospital care, the cost of which proves a burden. Combined with a system of district nursing in the puerperium, the number of patients who need hospitalization may be greatly reduced. I have omitted, for the sake of brevity, a number of details to which careful attention must be given to make the working out of the scheme a success but the proper development of which will suggest itself immediately to anyone familiar with the problems involved in the care of patients confined at their homes.

I have indicated that the problems of nursing are not for the nurse alone; they involve hospital administrator and physician as well; and that the preparation of the nurse for her work is an educational procedure with its implications as to understanding, capacity and character, not forgetting the essentially religious nature of education.

I have pointed out that there is need for the university school of nursing but that such a school should be a graduate school, rather than a development of the school giving the basic education in nursing.

I have sketched briefly and somewhat hastily the part the nurse should take in maternal welfare, which is one of our great social concerns.

I have pointed out that we may expect a great development of nursing in the field of maternal welfare.

I have suggested a practical scheme for improving the training of the nurse in certain fields of maternal welfare, which also improves the care of the patients confined in their homes.

I have passed over very lightly certain practical difficulties, ignoring for the present their existence; for example, the money cost of education. Education is costly, but it is less costly, in the long run, then uneducation, or the lack of education.

And so in the matter of nursing and maternal welfare I have presented nothing new. The facts I have discussed are known to you all; and the interpretation to which I have called your attention has been made by others before me. But I have desired to emphasize certain points in that interpretation and to remind you of some of the ancient landmarks which it is the part of wisdom not to destroy, so that in the rapid change but slow progress of contemporary life we may not walk in circles, nor even perhaps walk backwards, but step by step may draw closer to the goal of all our social endeavor, which is that every human being should have the fullest opportunity to become that which he was created to be.

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THE DIAGNOSTIC VALUE OF CHOLECYSTOGRAPHY

Analysis of the Results in One Hundred Operated Cases at the Massachusetts General Hospital

BY FREDERICK T. LORD, M.D.*

IN an attempt to estimate the value of cholecystography I have correlated the results in the routine use of the test with the operative findings in 100 cases at the Massachusetts General Hospital. In almost all instances the oral method of administration was used. The decision regarding the results of the test was made by the X-ray Department of the Hospital and I am indebted to Drs. Geo. W. Holmes and Richard Dresser for reviewing the X-ray data in all cases in which there was normal or abnormal tests of function with an abnormal or normal gall bladder, respectively. The 100 cases are unselected, with the exception of the substitution of random cases in a few instances in which the X-ray data, on revision, seemed unsatisfactory to the X-ray Department.

Cholelithiasis was found at operation in 61 cases. In this group there was evidence of abnormal function of the gall bladder in 55 (90.1%), normal function in 6 (9.8%). Gall stones were demonstrated by X-ray in 18 (29.5%), including 3 of the cases with normal function. Abnormal function or gall stones were demonstrated by the test in 58 (95%) of the 61 cases. Cholecystitis without stones was found at operation in 18, and in this group abnormal function was found in 15 (83.3%), normal function in 3 (16.6%). In the remaining 21 cases the gall bladder was found normal by the surgeon. In this group cholecystography showed normal function in 10, abnormal in 11.

THE DIAGNOSIS OF NORMAL GALL BLADDER FUNCTION BY CHOLECYSTOGRAPHY

In 19 cases in the series the gall bladder function was reported normal (Table I). The gall bladder was found normal at operation in 10 and pathologic in 9. The percentage of correctness of a normal function test as an indication of normal gall bladder was 52.6%. Of the nine

TABLE I

Diagnosis of Normal Gall Bladder Function by Cholecystography.

No.	Normal gall bladder at operation.	Pathologic gall bladder at operation.	Percentage of correctness of the test.
19	10	9	52.6%

cases with normal function and gall bladder pathology, stones were found at operation in 6 and cholecystitis without stones in 3. The gall bladder was removed in the nine cases and the pathologist reported subacute or chronic cholecystitis in all.

THE DIAGNOSIS OF ABNORMAL GALL BLADDER FUNCTION BY CHOLECYSTOGRAPHY

In 81 cases in the series the gall bladder function was reported abnormal (Table II). The gall bladder was found abnormal at operation in 70 and normal in 11. The percentage of correctness of an abnormal function test as an indication of an abnormal gall bladder was 86.4%.

TABLE II

Diagnosis of Abnormal Gall Bladder Function by Cholecystography.

No.	Normal gall bladder at operation	Abnormal gall bladder at operation	Percentage of correctness of the test.
81	11	70	86.4

At operation, in the 11 cases with abnormal function and normal gall bladder, duodenal ulcer without perforation was found in three, malignant disease of the pancreas in two, acute or subacute appendicitis in two, and primary carcinoma of the liver, salpingitis, abdominal adhesions and an appendix which on removal

*For record and address of author see "This Week's Issue," page 794.

was reported normal by the pathologist, in one each.

DISCUSSION

Certain factors complicate the problem of an attempt to determine the value of cholecystography in the diagnosis of gall bladder disease by the results in an operated group.

A normal function test with gall bladder pathology occurred in this series in 9 of 79 cases, or 11.3%. Reliance on a normal function test as an indication of the absence of gall bladder pathology tends to deter the surgeon from recommending operation on patients with normal gall bladder function and hence to exclude a certain number of such patients from the operated group. The more dependence the surgeon places on a normal function test in the decision not to operate, the more nearly will his statistics approach 100% of correctness for the group of patients with gall bladder pathology. If, for example, the 9 patients with normal gall bladder function in the 79 with gall bladder pathology had not been operated, the percentage of correctness of the test in the remaining 70 cases would have been 100%. The occurrence of normal function with gall bladder pathology limits the diagnostic value of the test.

An abnormal test in the presence of normal gall bladder occurred in 11 of 21 cases, or 52.3%. As the gall bladder was not removed, judgment regarding its normal condition rests with the surgeon, and there is opportunity for error in his interpretation. Inasmuch, however, as abdominal pathology elsewhere than in the gall bladder was demonstrated in all but one of the eleven cases, the inference may be drawn that a disturbance in the normal physiologic activity of the gall bladder may occur from intra-abdominal disturbances elsewhere than in the gall bladder itself. Such modification of function of the normal viscus limits the diagnostic value of the test.

CONCLUSION

The determination of gall bladder function by cholecystography is of great diagnostic value, but, whether positive or negative, cannot alone be relied on to indicate the presence or absence of gall bladder pathology.

THE EFFECT OF LATERAL POSTURE IN THE EXAMINATION OF THE CHEST

BY HAROLD W. DANA, M.D., F.A.C.P.*

FOR some years past, I have been interested in observing the fact that when a patient was examined lying first on one side and then on the other side of the body, there was a difference in the percussion note over the bases of the two lungs. In either position, when the lungs were reasonably free from pathology, there was better resonance over the lower lung. In fact, this observation was first noted as a confusing sign in pneumonia, where the patient, often too ill to be made to sit up, and necessarily having to be examined lying on one side, might even show better resonance over the consolidated lung when that lung was nearer the bed. That patients who were unable to sit upright should be examined in *both* lateral positions has been demonstrated to students and internes for several years.

In 1923, Adams and Pillsbury published their results from the study of a series of normal subjects examined in the lateral posture[1]. These authors noted that the diaphragm on the dependent side rose higher into the thorax, that its curvature was greater than in the upright posture, and that this lower side of the diaphragm moved more on respiration, while the upper side of the diaphragm in the lateral position was much flattened and its respiratory excursion was much diminished. The heart and mediastinum were found to sink toward the lower side, in the X-ray. In addition, the observation was made by these writers that tactile fremitus, the spoken voice, the whispered voice and the breath sounds were all increased over the base of the dependent lung. Changes in resonance were not considered in the observation of these writers. This increase in movement in the dependent half of the diaphragm was found by Webb and Sevier[2] to disappear after the subject had been lying on one side for from 30 to 60 minutes, at the end of which time the movement of the two leaves of the diaphragm become equal, or the predominance of movement may even be reversed. This last observation would seem to explain why patients with pneumonia so frequently prefer to lie on the affected side.

In the study here presented, it was desired to try to correlate the signs of apparently increased density in the dependent lung,—increased tactile and vocal fremitus, whispered voice and breath sounds,—with the presence of better resonance over this same dependent lung. The subjects examined were "run of the mine" from a general medical service, and while the majority were believed to have normal chests, many of them had definite pathological changes in the lung or pleura.

In general, all of the lung signs, resonance, tactile and vocal fremitus and breath signs, were louder in the dependent lung in normal chests. Whispered voice sounds were not very depend-

*For record and address of author see "This Week's Issue," page 794.

able, as the change in intensity was not easily determinable. The two signs most constantly to be found increased in the lower lung, even in many cases where there were abnormal physical signs in the upright position, were resonance and breath sounds. In many cases the signs in the lateral positions conformed to the predominant abnormal signs in the upright position. Especially was this true in regard to the spoken and the whispered voice.

As regards resonance, it has been suggested that the increase in resonance in the dependent lung is due to the nature of the support on which the patient lies,—that this increased resonance comes from the spring or the mattress of the bed. This explanation, as a matter of fact, is in part true. It is readily demonstrable that good resonance may be obtained by percussing with the hand as the pleximeter lying directly upon the mattress of a spring bed; even better resonance can be elicited by percussing a pillow. Insofar merely as regards the *increase* in resonance in the lung nearer the bed, it seems certain that this increase is transmitted from the mattress or spring, but this explanation accounts for only half the facts. This increase in resonance over the dependent lung is in part only apparent or relative, due to the decreased resonance of the upper lung which is not in contact with the mattress.

To get further light upon this part of the problem, five series of parallel tests were made.

In one series of examinations, the patient was placed in the lateral position on a bare wooden table with pillows under the head. Here there were two difficulties. In the first place, the wooden table itself gave a fair resonance to percussion, somewhat of the wooden tympany type, and also since the table did not sag under the patient's weight, the posture was not that of a patient lying in bed. However, the results in this series were like those obtained with patients in bed.

Next it was tried supporting the patient's chest away from the wooden table by means of piles of blankets placed under the hips and under the shoulders. Here again, there was some resonance to be obtained even from percussing the piled-up blankets, and the results were similar to those found with patients examined upon a mattress and spring.

After long search, an old-fashioned "fish net" hammock, of double strand whip cord tied in a diamond mesh, was obtained. In some respects this seemed very promising. The hammock itself was non-resonant, but the results obtained were confusing. For one thing, it was extremely difficult for the operator to get in a position in which the lower lung could be percussed freely and easily and at times it seemed as if the pressure of the cords damped the vibrations of the lower lung. So that while in general the physical signs conformed fairly well to those obtained with patients lying on one side in bed, the results were too inconstant to give any dependable evidence.

Interesting results were obtained in a series of tests comparing the chest signs when the patient extended the dependent arm, with the signs found when he lay with his chest resting on the dependent arm. As a rule, the resonance and respiration over the dependent lung were the same in either case, both signs being slightly greater than over the upper lung. In the case of the upper lung, however, there was much better resonance when the patient was lying with his chest resting on the dependent arm, than when this arm was thrust forward clear of the body. This particular point has a definite bearing on the means of production of the decreased resonance in the upper lung, for quite evidently the spine cannot be so much bent, nor the ribs so much compressed, when the natural sagging of the body on the bed is limited by the support of the arm.

All of the studies of physical signs here made have been supplemented by fluoroscope examinations in both lateral positions with the patients lying on a rigid table. One point brought out by fluoroscopy gives strongly corroborative evidence in regard to the fact that, independent of bed-spring or mattress, there is actually better resonance at the dependent lung base than over the upper lung. As noted by Webb, Forster, and Gilbert[3], the base of the dependent lung, on deep inspiration, normally shows the best illumination in the fluoroscope of any part of either lung. In fact, where there are lacking good-sized equal areas of illumination at the dependent base in each lateral position on inspiration, it is an indication of a pathological condition on the side where this lighting up is absent or diminished in size.

It would seem reasonable to argue that if there is better aeration at the dependent lung base, as evidenced by fluoroscopic "lighting up" on inspiration, this brilliant area should be expected to give better resonance than the less illuminated parts of the lung.

Lastly, the simplest procedure of all was resorted to, and the most conclusive evidence obtained thereby. If the physical signs be obtained first with the patient sitting upright and then with the patient bending his back laterally towards either side in turn, it will be found that the resonance is increased slightly over the convex side of the chest, as a rule, and that the resonance is always much decreased over the concave side of the chest. The other chest signs are variably influenced by this manoeuvre, but the resonance follows what is to be found in examining a patient with a kyphoscoliosis, that there is improved resonance over the convex area, decreased resonance over the concavity.

This seems to be the explanation of the other part of the change in signs in the lateral recumbent position. Hence while the bed resonance adds something to the resonance of the

dependent lung, the loss of resonance in the non-dependent lung is due to the concavity of the spine on the side away from the bed, with resulting compression of the ribs.

Adams and Pillsbury[1] explain the increase in the other physical signs in the dependent lung as due to compression of this lung by the sagging of the mediastinum toward the bed. If this is true, as it seems reasonable to suppose, then one would not expect to get this influence on these other chest signs when examining a patient sitting upright with the back bent toward one side. This is perhaps why the examination of patients sitting upright with flexed back gave no certain effect on physical signs other than resonance.

The only other feature of interest in the physical examination of the lungs in the lateral position is that when râles are present at one or both lung bases, these râles are much better heard in the lung nearer the bed, and are usually not to be heard over the uppermost lung, even when this is the diseased lung. This observation was made by Morrison[4] in regard to the râles of pulmonary oedema, and was apparently regarded by him as due to the mechanical shifting of the fluid.

CONCLUSIONS

1. Since it is frequently necessary, in patients too ill to sit upright in bed, to examine the chest with the patient lying on one side, changes in the physical signs over the lungs in the lateral positions are of clinical importance.

2. Frequently, the physical signs in the lungs are quite confusing in the lateral position, so that it is often difficult to determine on which side consolidation is present.

3. Normally, the dependent side of the chest shows increased lung signs; increased spoken and whispered voice and louder breath sounds. At the same time, there is improved resonance over the dependent lung, and decreased resonance over the non-dependent lung.

4. The improved resonance over the dependent lung is largely transmitted from the mattress and bed spring, while the decreased resonance over the upper, non-dependent, lung is due to compression together of the ribs of the concave upper side of the chest, as the result of the curvature of the spine from the natural sagging of the bed spring.

5. Râles, when present at the base of one or both lungs, are better heard over the dependent lung.

6. To get a fair conception as to pathologic changes in the lungs in patients unable to sit upright in bed, such patients should be examined in both lateral positions.

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THE NEW ENGLAND MEDICAL COUNCIL

Maine Medical Association Meeting, June 19, 1928

PRESIDENT TWITCHELL. As President of the Maine Medical Association, it is my privilege to extend to the Council our welcome to this place where we meet today, and we trust that you will feel free to attend the meetings and stay as long as you care to.

DR. PARKER, President of the Council: First on the program are the minutes of the last meeting.

The minutes of the last meeting have been put into booklet form, and have been distributed. It will take about twenty minutes to read them, but I will be very glad to do so if you wish.

Upon motion duly seconded, it was

Voted that the reading of the minutes be omitted.

This is the annual meeting, and is the meeting at which the election of officers for the ensuing year will take place. I am going to express a personal opinion. In this organization, it seems to me that the best results will be obtained by having the office, at least of the president rotated each year from one State to another. This organization is a very young child as yet, and needs strong guidance. I would like to have you give this matter careful thought when making nominations.

Upon motion, duly seconded, it was

Voted that Drs. Bryant, Luce and Wheeler be declared a nominating committee to present names for president, vice-president and secretary-treasurer and the executive committee.

To go on with the program for this meeting, we will take up education relating to the practice of medicine and the problems therein. I think you all feel as I do, that within the last ten or fifteen years a marked change has come over the attitude of the public toward all things, business and professional. The public seems to grasp more readily at anything that is put before it in print, radio or any other way in a logical and pleasing manner. We have seen in the clubs and in the business houses, etc., the increase in advertising. There is no question in my mind but that today, we as a medical profession, knowing these facts, seem to be standing still and even losing ground in the eyes of the public. I believe it is because we are rather poor merchandisers. Now what attitude are we going to take in merchandising our goods? I think that is one important thing we have got to discuss. There are many other facts to be brought out. I am going to call on Dr. O'Brien to talk to us on Education of the Public with Reference to the Cults.

EDUCATION OF THE PUBLIC WITH REFERENCE TO THE CULTS*

BY THOMAS J. O'BRIEN, M.D.†

IN discussing this subject, we must first prove the right of modern medicine to brand those groups practicing the healing art in opposition to our teaching, as cults; and secondly, to define our duties to the public concerning their practices. It is with pardonable pride that we point back to the year 1552 B. C., as the translation of a roll of papyrus found in the pyramids, proves conclusively that a knowledge of medicine was known, and practiced by the ancients at that early date. It is an interesting and instructive study, to trace the history of the healing art, through the many intervening centuries, up to the present time. During these thirty-five hundred years, whatever has been of value has been retained, and the animal, vegetable and mineral kingdoms have been carefully searched for those products most applicable for the alleviation of suffering and cure of disease.

In the last hundred years, we have standardized our drugs by the creation of a pharmacopoeia, the result of a Medical Congress held every ten years; we have standardized our medical schools and hospitals, not by Federal, State or Municipal Statutes, but by a convention of delegates from within our ranks; and we have standardized our methods of practice by examination by our National and State Boards of Registration. Briefly, two ideals dominate our actions, namely, our devotion to the public welfare,—and the advancement of scientific medicine.

Although comparisons are said to be odious, let us remind our lay friends, that Pasteur, Lister, Erlich and Curie have saved more lives than Caesar, Napoleon and William Hohenzollern have been instrumental in killing, and that while the average individual is well instructed by the public press in the glorious accomplishments of Lindbergh, Tunney and Jones, the really great heroes like Reed, Dodd and Nogouchi, who made the supreme sacrifice for the welfare of their fellowmen, are practically, as the poet says, unknown, unhonored and unsung.

In the principles of medical ethics of the American Medical Association, we find in Chapter I, Section I, that, "A profession has for its prime object, the service it can render to humanity; reward or financial gain should be a subordinate consideration"; and in Chapter III, Section III, on the duties of the profession to the public, the following words, "Physicians should warn the public against the devices practiced,

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†For record and address of author see "This Week's Issue," page 794.

and the false pretentions made by charlatans, which may cause injury to health and loss of life." It therefore becomes not only our right, but a solemn duty to oppose the cults.

In the period of the Renaissance, when the world produced the famous masters of art, literature and education, as Shakespeare, Bacon, Columbus, Raphael, Leonardo de Vinci and Michelangelo, it also featured the introduction of Paracelsus and Hahnemann, who became leaders of their respective medical cults, the first in medical history. Galen, you may remember, was born in 130 A. D. and became famous by his ability to collect the salient facts from the accumulated knowledge of medicine, up to his time, and then outline the necessary requirements for study, that all physicians might be educated along definite lines. His scheme of education dominated the world, for thirteen hundred years. Paracelsus astounded the world, by claiming that chemists should cease wasting their time trying to make gold, and devote their attention to the use of chemicals in treating diseases. A breach was made in the ranks of the physicians, as up to that time only botanical preparations were used in medicine, but, in passing, I would say that now a knowledge of chemistry is required for entrance to a Class A school. This fact is emphasized, that the world may know that the medical profession gladly welcomes any innovation in drugs, diet, heat, light, electricity, manipulation or massage, if their respective values are proven by practical investigation to be of help to mankind. Hahnemann built his system upon the well-known theory of similia similibus curantur. In passing, I would say that there are very few colleges now teaching homeopathy, and about three fourths of the members of their society in our state are also members of the Massachusetts Medical Society. Our joint committee on State and National Legislation consists of five members of our Society and five members of the Massachusetts Homeopathic Medical Society, the president of our society being chairman.

The present cults are of recent origin, and will be discussed separately: Christian Science is a religion, and every man has a constitutional right to worship God as he elects. I shall not criticise another's belief. Trangression of the law governing the practice of medicine calls for punishment by civil authorities. Electicism is now practically extinct, and requires no discussion.

About 1906, the Massachusetts Osteopathic Society petitioned the legislature to create a separate board to examine and license osteopaths. The bill was defeated. The leaders took counsel, and decided to include the basic science subjects in their curricula, so that they could pass the examination of the Board of Registration in Medicine. On the whole, the osteopaths have been satisfied with this scheme, although during the last session they again introduced a similar bill. They were given leave to withdraw. The president of the Osteopathic Society has appeared at the various hearings in opposition to the creation of a separate board to examine chiropractors. His society takes the stand, that if separate boards are to be created, naturally they want an osteopathic board, but otherwise, they are satisfied with the present single standard. The Massachusetts Board of Registration in Medicine consists of seven members, one of whom is an osteopath, and of the others no more than three can be members of the same medical society. The secretary of the present board is an osteopath. Many of the osteopaths have taken post-graduate courses at polyclinics, and they have stated at hearings, that they now practice regular medicine, using osteopathy for special conditions.

The *Journal of the American Medical Association* of May 26, 1928, devotes much space to a very thorough report of inspection of all the naturopathic and chiropractic schools of this country, and sums up its conclusions by the statement that not one of these schools that does not owe its existence to the fact that it offers a short cut to the practice of medicine. According to this article chiropractic was introduced by D. D. Palmer, a magnetic healer of Davenport, Iowa, in 1895. Their theory is, that disease is due to vertebral subluxations, which cause a pinching of spinal nerves between bones. This pinching interferes with the flow of "Innate Intelligence" or vital energy to the body tissues. The spinal "adjustment" alone renews that flow and restores health. Naturopathy started in New York City in 1896, under the guidance of Benedict Lust. No theory is obtainable from their literature, other than a great hatred for drugs. A chiropractor may take a three months' course, and become a naturopath.

It must be apparent to every fair-minded reader, that students in these schools are improperly prepared for the emergencies and the serious problems of the operating and sick rooms. There are practically no requirements for preliminary education; no courses in physical diagnosis, pathology, surgery, obstetrics nor contagious diseases; no interneships; and no specialties. We learned, that the criticism of their lack of diagnostic methods, induced some chiropractors to invent an instrument to do that little thing for them. This was said to be called a neuroclast, and the act of placing this instrument, so that it touched the successive vertebrae, produced the correct diagnosis. I regret that I cannot describe it more minutely, but I have never seen the neuroclast. At Westmoreland, New Hampshire, was situated a psychopathic hospital, where the patients were treated by the chiropractic method. Any comment by me is unnecessary, as the entire theory is incorrect, unscientific and impractical.

The method employed by the legislative committee of the Massachusetts Medical Society in

educating the public, concerning the chiropractor, may be apropos. About five years ago, we learned that this cult had introduced a bill asking that a separate board of chiropractic be established, and that those successful in passing the examination "be given the rights and privileges of physicians". Although surgery, medicine and obstetrics were not taught in their schools, yet they asked for the authority to administer pre- and post-natal care, "except at the moment of parturition". At the very moment when two lives depended upon the knowledge and skill of the obstetrician, they asked for permission to be exempted from all legal responsibility. We soon became aware of the great strength of our opponents, as attorneys, publicists, politicians and lobbyists became very active in their behalf. The hearing was held at the Auditorium, as no room in the State House could hold the eight hundred or more appearing in favor of the bill.

The biblical story of David and Goliath seemed to describe conditions perfectly. The chiropractors being so strong, well-armed and over-confident were well typified by Goliath, while the Massachusetts Medical Society reminded one of David, being practically un-armed and unskilled in the art of vocal warfare. As you know, Goliath was defeated by a stone. There, gentlemen, is the stone. Dr. James S. Stone decided that the forty-four hundred members of our society were most strategically placed throughout the state in every city, hamlet and town. A slogan of "one standard for the qualification of fitness to practice medicine in the Commonwealth of Massachusetts" was coined and was repeated again and again by every speaker opposing the passage of the bill. Letters from the presidents of the colleges in our state were read, endorsing our policy of a single standard. Similar letters were filed with the committee, from the State Commissioner of Health, and Boards of Health from various cities; from the medical directors of all the life insurance companies who were vitally interested in the subject; from medical examiners; from the Commissioner of Education; from hospital superintendents; from dental and nurses' societies; from Chambers of Commerce and from many influential and public-spirited men and women. Headquarters were established adjoining the editorial rooms of the NEW ENGLAND JOURNAL OF MEDICINE, and an efficient body of secretaries was always at hand to supply speakers for all social, fraternal or civic gatherings. In all possible ways, the general public was kept informed of the grave danger of lowering the existing standard, and the physicians did heroic work in their respective localities in informing the senator and representatives of the opposition of their constituents to this bill.

At the hearing, we stressed the admitted inability of chiropractors to diagnose communicable diseases. We also spoke of the specific drug treatment of syphilis, malaria and diabetes, and the training necessary for the administering of such treatment. Our principle of a single standard, and our devotion to the public welfare and advancement of scientific medicine won us many adherents in the public press and throughout the State. The more our profession was investigated, the greater was the praise for self-sacrifice, charity and skill. The chiropractic bill was defeated, year after year.

There is a serious side to this subject, and we must acknowledge that even the temporary success of a cult is evidence of some defect in our personal or professional methods of treating the sick. Oliver Wendell Holmes once said to a young physician, "Cure if you can, but always console," and this same advice is just as good today, as when it was first given. Lack of consideration of a patient's desire to fully state his symptoms in detail, and a too brusque manner in deciding immediately upon a serious operation, may influence a person to consult a more sympathetic listener, possibly a Christian Scientist. A caustic criticism of massage and electro-therapy may add gloom to the hemiplegic and chronic arthritic, but cannot something be done by us as well as by the osteopath? The success of the physio-therapy departments of our hospitals proves the value of this method of treatment in the public mind, and must be viewed favorably by us. Our method of mishandling functional diseases calls for serious study. It is unwise and unfair to give an offhand statement to a patient, that there is nothing the matter with him, when he fears that he has some serious ailment. He is entitled to a thorough physical and laboratory examination, and, an opinion rendered in careful, well-chosen language will satisfy him, and possibly keep him from a cultist who may let him have his dreaded cancer or whatever he fears,—and then claim to have cured him of it, when the patient decides that he is well.

Some years ago, at an address on Benjamin Franklin, Arthur D. Little, ex-president of the Chemical Society spoke of an occurrence in the British Parliament, when Edmund Burke mentioned that that body was assumed to be composed of representatives of three estates: the lords spiritual, the lords temporal and the commons. Burke pointed to the press gallery and said, "There sits a Fourth Estate, more important far than all." Mr. Little proposed Franklin as a representative of the Fifth Estate, an estate destined to play an even greater part than its predecessors in the remaking of the world. The Fifth Estate is composed of those having the simplicity to wonder, the interest to question, the power to generalize, and the ability to apply.

In short, it means, an educated, professional man, and your training and character, your influence in the public welfare and opportunity to aid the sick and needy, and your devotion

to medical progress places you in the Fifth Estate. As such it becomes, not only your right, but your duty to educate your patients, your friends and your community against the dangers of the medical cults.

This paper will be discussed by Dr. James S. Stone.

DR. STONE: I think that the last part of Dr. O'Brien's address contains everything I intended to say. There is no enduring cult that has not its origin in some sign of omission or commission on the part of the regular medical profession. I mean one which endures. The chiropractors are not enduring. Their number of students has fallen off tremendously. Of course they will run on from their own momentum for a certain number of years, but as an aggressive factor they will never be as strong as they have been in the last few years. In the legislature they may seek a new board if they feel there is any chance of securing one. Our neglect of physical therapeutics is one of the reasons why osteopaths and chiropractors have had their practice.

The neglect of the psychology of the patient and the craving for some faith is the cause of the growth of Christian Science. We neglect functional diseases. All of us at times rejoice when a patient whom we know has no organic disease and whom we know we cannot cure turns to Christian Science. Physicians are prone to neglect the psychological problems of these cases which have no distinct pathology. A patient may be offended if a doctor tells him there is nothing the matter with him. The patient may say, "He is a wonderfully good doctor, but he doesn't understand my case." That same patient may, a little later, go to a Christian Scientist and readily accept the same statement put in a little different language. The readiness of the patient to accept the fact that there is nothing the matter with him and the way in which this is stated are all important. That indefinable religious factor which plays such a powerful part in our lives also has an influence.

We have overdone the standardization of medical education. There is every reason to believe that this over-standardization will soon pass. The tide has turned. We shall in time be free from the effects of the over-standardization. Two words are a curse in education. They are standardization and efficiency. I wish we could get rid of these two things.

As Dr. O'Brien has stated the education of the public is the only remedy for the cults. We must educate and keep on educating. We are in constant danger in the legislature, in legislative committee hearings and in public discussions of every sort, if we have not one to back us outside of our profession. We must talk to the public so that they may understand us and our aims and ideals. Public education is the only safeguard and only protection from the cults.

DR. BLUMER: In the first place, I would like to echo what Dr. Stone said about the dangers of organization. I don't know whether some of you saw, a number of years ago, a short article in one of the popular magazines, Scribner's or Harper's, which was supposed to give an account of a conversation which took place between the devil and a certain individual of this world. This individual in talking to the devil asked him if he was not afraid of the activities of a certain group of people. The devil said that did not worry him he had all that fixed. He had persuaded them to organize. All of us know that a certain amount of organization is necessary but after all what we want is the right spirit. Another point: I think in fighting these cults we have got to be more careful how we go about it, and be particularly careful not to make the mistake that has been made before, and that is to descend to nothing that might be interpreted by the public as abuse, for just as soon as they appear in the light of martyrs, we are going to be in great danger of increasing their following, rather than reducing it.

DR. HYATT: I don't know that I can say much more on this subject. I think the attitude of the physician towards these cults is of very great importance. It should be, not to make martyrs of them. It is very difficult to say the right thing. We feel what they are doing and we know what they are doing, but the minute we try to tell our patients about it they feel there is "a reason" on our part. It has seemed to me that if we could get some good speakers to talk over the radio we might, perhaps, get somewhere: Someone who is able to speak to the public, that is, in a way that would give them the information without arousing this spirit of jealousy.

DR. GILBERT: It seems to me that this subject has been covered very well, and I was much interested. We have our troubles in Maine, and have been up against the problem of the osteopathic bills. We have decided not to oppose any new cult legislation coming up before the coming legislature. There have been bills before our last two or three legislatures, which if passed would give them the rights to do surgery and obstetrics. Education of the public is the keynote. Obtaining letters from the various college presidents and men prominent in business, endorsing a single standard of medical education and a single board of registration would be of value to the legislative committee.

DR. COBB: This question is of great interest to us in New Hampshire. I am sure I have no solution, but have a few suggestions to make. We have in the City of Berlin, N. H., 18,000 people, 15 physicians, 2 chiropractors and 2 osteopaths. There is no controversy between the physicians and the cults in our city, and as far as I know the medical profession simply

ignores them. We don't interfere with them, so know little or nothing about them. But they have a lot of practice among well-to-do people, and the reason for it I do not know. I have thought about the matter a great deal, but have not determined in my mind what the reason is. One osteopath is a very busy man, and attends some of our most well-to-do and most intelligent people. It seems to me that the people of intelligence who employ the osteopaths, really find something which the medical profession failed to give them. I have a feeling that the fault is with us. What our patients want we have failed to give them. I think it has been suggested that we have got to change our attitude, and give the people more what they want. One thing I think, especially with many doctors, is the tendency to make hurried calls, write a prescription, get in and get out, in too short a time. We do not get in touch with the patient enough; we don't know what they want nor what they believe. I think we are to blame for a big amount of business that is done by the cults.

Another thing which I believe we are at fault in is this: We have a hospital of 50 beds. Many doctors are prone to find the patients very sick, and tell them they must go to the hospital. This costs money, and is more expense sometimes than they can afford. People may have turned to the cults because of this. We send people to the hospital for an operation which they don't need. Many people are afraid to call in a physician feeling that he will rush them to the hospital, and do something they don't need to have done, and so they call in an osteopath. If they can get along without hospital expense, they wish to do it. I have never known of an osteopath putting a patient in a local hospital. The people get well while the osteopath is giving them some sort of treatment. We have driven the patients away from ourselves, into the hands of the cults.

DR. TWITCHELL: I extend the welcome of the Maine Medical Association to the New England Medical Council, and would say that we feel very highly complimented that you have taken the trouble to come to this somewhat out-of-the-way place to attend our meeting. In regard to the question in discussion, I highly endorse what Dr. Cobb has just said.

DR. SULLIVAN: It seems to me that a remark made by Dr. Gilbert should receive some comment. If I understood him correctly, he was of the opinion that the efforts of the cults to obtain legislation should not be opposed. That is where we have fallen down very much in the past. It also occurs to me that one of the greatest functions of the New England Medical Council should be to supply the New England states with arguments and speakers during the legislative sessions. I think we should oppose the cults. The public has told us that we are to blame in a large measure for not enlightening them on things in which they are so vitally interested, and the so-called advantage they get from the cults is absurd. It is one of the things I hope to see emanate from this organization and the president should call upon some representatives to put these matters right. I certainly believe Dr. Gilbert must have the right ideas about enlightening the public. If we can endeavor to put this forth in the right manner, I am assured that there will be a reaction in the public mind. It is surprising to note among lawyers, business men and college men their ideas on these questions and the attitude they have toward the medical profession. In regard to publicity—in writing this detailed report, a thought came to me that we were making a mistake. It is going to be quite an expense to publish the minutes of these sessions and again the laity may use what we say to our disadvantage.

DR. GILBERT: After contesting cult legislation for a period of years, the unpleasant reaction toward the profession led us to feel that we should withdraw. They now have separate boards, entitling them to practice medicine, and it is only a question of time when they will be able to do surgery and obstetrics. One point should be borne in mind. When we start the practice of medicine, we are a little more enthusiastic in promising cures than we are 25 years later. We are more conservative then. On the other hand, take the cults. It is a case of a little knowledge being dangerous. They will promise a cure for anything. It is what the public wants. The more knowledge you get the more hesitancy you have in promising anything at all. The cults will promise anything, but they collect the money at each visit.

DR. COBB: If a physician promises a cure, and fails to cure, he is legally liable. If an osteopath promises a cure and fails, is he legally liable? I have never known of an osteopath being held liable if the patient was not cured according to agreement.

DR. BOWERS: This is a very complicated matter which has to be handled with consideration of divergent opinions. We must recognize that there are two sides to nearly every story. It seems to me that the medical profession is just as much under responsibility to the public to give correct information on these matters as is any other professional body dealing with public health. If the medical profession should be vague on the question of information, would we not all feel that it had failed to do its duty? Even then, there is a certain amount of reaction and some damage when doctors, who as medical men, fail to answer these questions in a reasonable way. A few years ago, a certain physician in Massachusetts had for years devoted himself to the task of opposing vaccination. Finally he exposed himself and contracted the disease and he was convinced of his folly. The Massa-

chusetts Medical Society has consistently opposed anti-vaccination, and has done everything in its power to instruct the people of the danger of smallpox. Even though there may be some harm therein, we must maintain our self-respect by teaching the people as well as we are able to show them that we are protectors of health so far as we can do so.

With reference to the last question. If the osteopath promises a cure, is he liable? In all probability he is, if the matter should be presented to the courts. If a person enters into a contract and fails to keep it, he can be sued for failure to carry out his particular agreement. A case of this kind has never been in the courts, as far as I know, but it seems so logical that I think if a case of this nature were in court, the result would be that damages could be secured. A certain man who practiced osteopathy at one time, promised cures, and he was brought before the Board of Registration. He did not live up to his promises and his license was revoked. It was never contested in the courts, and this probably was because the man did not feel that he had reasonable ground for any fair kind of action against the board. If the board can relieve the man of the right to practice because of his promise to cure, and his failure to cure, it seems to me that the courts would be very likely to suppose that any action could be carried through against any person who failed to meet a definite contract.

DR. O'BRIEN: "In reply to Drs. Blumer and Pritchard, I would like to describe in greater detail what was done in Massachusetts by organizing. Our Committee would carefully study an objectionable bill and outline a definite policy of attack. At the hearing, certain competent speakers would briefly discuss definite issues, not touching the subject matter assigned to others. We discouraged impromptu orations on the part of physicians who happened to be present. We featured the slogan of 'One standard for the fitness to practice medicine in Massachusetts,' and had it repeated again and again by those speaking in opposition to the bill.

We were careful not to mention the cults in any way, and at a hearing when Dr. James S. Stone was asked by a legislator if the Massachusetts Medical Society opposed Chiropractors practicing in the State, he answered, 'No, not if they pass the present requirements, namely, the examination given by the State Board of Registration in Medicine.' This they were unable to do.

Permit me to emphasize the importance of instructing the general public in our policies. This was done by interesting our members in the problems and requesting them to discuss the principles involved with patients and at all social, civic and fraternal meetings. Interviews by constituents with local legislators were of the greatest value. The creation of a headquarters where a competent executive received reports from the various districts and directed the campaign of education was most satisfactory. We are convinced that but little is accomplished by simply appearing before a legislative committee. Much can be accomplished by proper leadership and organization."

EDUCATION OF THE PUBLIC WITH RESPECT TO PUBLIC HEALTH PROBLEMS*

BY W. G. RICKER, M.D.†

THE question of education is broad, including on the one hand University courses of the highest order, and on the other hand, public propaganda of the loosest sort, but in any case, there are certain fundamentals to be considered. First, the subject itself; second, the pupils; third, the teachers; and fourth, the methods of instruction.

We will dismiss some of these in a few words. The teachers are recruited from the medical profession with public health workers possibly considered as experts; the pupils are the lay members of the community. Before leaving this, however, one should observe that generally speaking the pupils are more desirous of obtaining knowledge than the teachers are of giving it. This is shown by the many lay organizations calling for talks and literature on public health questions as compared with the lack of an organized movement to impart this information by those qualified to give it. Of the greatest importance, however, are the subjects to be taught, and the methods of teaching. Public health may be considered as the health of individuals taken collectively. The individual wishes a long life and a condition of good health while living, and measures which lead to this are always acceptable. The public health worker must do what he can to promote this condition. Law, custom, and experience have delegated to him certain duties. He is held responsible for regulations controlling contagious diseases. It is his duty to see that public buildings have proper light, heat, ventilation, and sanitation. Sources of drinking water, and the disposal of sewerage are placed in his domain, and under these headings, certain detailed tasks have been assigned to departments of public health.

The department of Public Health is empowered to make proper rules and regulations, the enforcement of which rests with the Department of Justice and said rules must be such as will be held reasonable by the courts. Moreover as a matter of fact it is necessary that these rules meet with popular approval if one expects adequate enforcement. We are familiar with the futility of an unpopular legal measure.

It thus becomes important that the public should understand health measures in order that their co-öperation may be secured. What

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†For record and address of author see "This Week's Issue," page 794.

then shall be the subject matter to be taught? What principles shall govern the selection of topics and how shall they be presented? The answers will be found included in the following discussion.

The topic stressed at a particular time should be a timely one, one in which there is a general interest at that special period. An illustration of this may be found in the epidemic of Rabies in New England, and particularly in eastern Massachusetts. Here there is a definite opposition to control measures, due for the most part to lack of knowledge of the facts. At least a good part of the opposition would evaporate at once if the general public were well informed. Moreover people are eager for the facts when once they become accessible. When a disease like this becomes rampant, put the wheels in motion at once and do not fear to be sensational which one can do without deviating one bit from the truth. Give interviews to the press, get a good writer to feature the disease in the Sunday edition in a well edited article, and print some pictures of microscopic findings. Show the Negri bodies and pictures of the laboratory, tell how the disease is proven, let the public know the grounds upon which opinions are based, and show how guess work has been eliminated from some phases at least of medical work.

Such information is of interest and will be read. This information must be repeated and the subject kept before the public. Publish all reported cases, let the people know the extent of the epidemic. If it is large, measures to quell it will follow; if of small extent, radical measures are not needed.

The subject chosen for presentation to the laity should be a reasonable one, that is, it should be one capable of demonstration and proof to the ordinary individual, and not so abstruse as to require the reasoning of a trained or technical mind to comprehend it. Several illustrations may be offered, one of which is that of small-pox. Would any one of you feel that you could meet an average audience and from your vantage point on the lecture platform convince them that small-pox is an impending danger and that universal vaccination is today necessary? And could you show them sufficient facts to convince them that each and every one should be at once vaccinated? If on the other hand small-pox is not at present an immediately impending danger and there are other dangers more capable of demonstration then the task is easier to switch to those more evident ones. Public health teaching is a continuing process; all cannot be accomplished at one time, and, in the selection of themes, thought should be given to the future as well as to the present. Timeliness and reasonableness are so related to each other that neither can be considered alone. When and if an epidemic of small-pox appears and in such form as to reveal itself, both as to life and disfigurement, then there will appear at once a greedy appetite for the facts and prophylactic measures become at once almost automatic.

The teaching must carry facts of definite value. Let us use the cancer question for illustration. We have here an abundance of funds clamoring to be used and we have a plenitude of willing publicists; we have a subject that certainly is a timely one, but we lack one thing. We are not able to tell any one how to control the disease. We are not able to show that we have an accurate means of diagnosis of the precancerous state, we cannot show that we can always be sure an abnormal condition is cancer in time to be of any value. The theories are valuable and doubtless are leading to a solution of the problem incident to this disease. But these theories are too deep for popular interest. Their intrinsic value goes unappreciated. "What can we do to be saved" is the popular cry, and the present answer does not satisfy. The public are asking for bread and too often are getting a stone. Why should the medical profession give the greatest publicity to the disease of which they are the most ignorant? And why make ourselves ridiculous by calling every wart and wen a potential cancer when popular experience teaches the contrary? I am not opposed to cancer publicity as such but even a good thing can be over-done.

Many of our highest type of physicians and one at least of our insurance companies are promoting the periodic or annual health examination. It is true that this system will discover many latent and otherwise unknown cases of cardio-renal breakdown but what is to be offered to the patient after the discovery? The public are not foolish and are well aware that as long as an individual feels well he is not sick and it is hard work to convince the average man that he should spend from five to fifty dollars to be told either that he is all right or that he has something that is going to show up in a few years and kill him and that he must quit work and liquor and go South in the winter and play only 18 holes of golf every other day, etc., etc., and that if he does all these things the disease will get him just the same.

These statements may be a bit extravagant and not quite fair but this is not a lay audience. There are many present here who can provide additional ideas.

Infant welfare and maternal hygiene are always timely and listeners are numerous and eager. Accurate knowledge properly disseminated on this subject will save many lives. Definite information of positive value can be supplied. But why give lectures on this subject to classes of high school girls? And why hold clinics to which the entire neighborhood is invited as has been done in a number of instances.

And shall there be an educational campaign concerning the perils of venereal disease? If knowledge is a preventive why do college students get burned by the sparks of passion the same as other young men? Why not go the

limit and include birth control and also the name of a manufacturer of a reliable device for contraception?

Destructive criticism and ridicule, however, are to be condemned unless accompanied by constructive suggestions, and here are a few.

The teacher should know his subject. The well-meaning social worker is not well grounded in medical lore, neither is a public health nurse with the ordinary training and experience. The doctors are the best and, in fact the only well-trained class in these subjects. When all is said the teaching of health matters should be confined to them. Moreover the doctors should recognize the fact that it is their duty to supply this teaching? If they do not others will attempt to do it for them as has been done in the past.

Topics of general interest should be taught by mass methods, but not every health topic is a general one. Many are individual problems and general advice is not applicable. Individuals must be taught to have faith in their medical adviser and the doctor must conduct himself so as to deserve this confidence.

All instructions must be accurate and truthful. It will do no good to call a spade a shovel and it adds nothing to popular welfare to exaggerate minor evils.

If the medical profession will assume the task of public health teaching and will develop an eagerness to impart this knowledge, ways and means will suggest themselves. Simply seize each and every opportunity to supply this knowledge where ever it is found lacking. A conversation here, a public talk there, newsprint and magazine articles with an eye always open and looking for an opportunity will accomplish much with persistence.

Conclusion:

Competent teachers should do the teaching. Other factors are secondary.

Dr. Blumer: I will take up the subject in the same order as Dr. Ricker did and discuss first the *teachers*. I think it is very important to recognize that not all physicians are competent to act as teachers. You have only to attend a medical meeting, and hear the discussions, to realize the fact that some men have the art of presenting their ideas in a clear, coherent way, and others have not, so whoever we pick out to represent us, should be accurate and precise. In the same way, whoever we pick out as writers should be able to present the subject in clear understandable language. We have tried to a certain extent in New Haven, to publish material in the press, but we found it is a difficult task to get men to put the material in a form that was suitable for publication.

It is very difficult indeed for a medical man to present medical topics in understandable language, and some of the writers of lay publications are just as bad as anyone else. The thing that impresses me is that the people who are most easily reached are the ones who least need instruction. How can we reach the ignorant and indifferent among the public. The only way we can reach them is through their physicians and instruction in schools. The text books that are used in schools now are decidedly prejudiced, especially as regards certain questions, and are not an example of the views of the medical profession.

In regard to the subject, I agree in the main with what Dr. Ricker has said. In regard to what he said about cancer I think we should not avoid a subject because we don't know all about it. I think it would be very unwise to go into the etiology. We may as well acknowledge that the cause is not known. The public is well aware of the fact that there are a great many things we don't know. Of course, we can emphasize some of the most important things about it.

Dr. Ricker said something on the subject of health examinations. I am inclined to think this is a subject that needs to be handled with great tact, for there is a side to it that has not been very much discussed namely the danger in certain classes of patients (unless we handle this with care) that are going to call attention to their health too much.

Finally, as to the *methods* to be used, Dr. Ricker does not mention some methods that may possibly be used very successfully. In the case of the methods we have to take a leaf out of the books of our adversaries, the cults. Dr. Ricker does not mention the possible use of educational films. Of course we know an extensive number of the public attend the movies, and we should use the films or radio. We know that through the radio we can reach a greater audience than we could possibly reach in any other way. But in all of these methods of education of the public, I would suggest that the educating be done by specially picked individuals, and should be very carefully supervised and carefully censored.

Dr. Wheeler: In justice to myself I want to make a little explanation. About two weeks ago I had a night letter from our Secretary from which I gained the impression that Dr. Rowley had prepared a paper on this subject and had requested me to present it. Afterward, I found out that the Secretary wanted me to prepare the paper. I had no time to write him refusing to do so and I have had no time to write the paper. Hence I find myself opening this round table discussion without having been able to give the subject much thought.

In discussing the question I think it would be in better form if the two words "public" and "physician" were transposed so that it would read "education of the physician" and "how to get the support of the public."

There is no class of men anywhere who have such an opportunity to influence public opinion

as the physicians. We are called into a family in cases of illness. The head of that family or the two heads of that family have absolute confidence in us or we would not be called in a case involving life or death. We should at such times improve the opportunity to explain to the people some of the things medicine has accomplished. This should be done in a diplomatic way with no attempt to belittle any of the cults etc., but simply to give the people a better understanding of what medicine has achieved in the past and what it is striving for in the future. Doctors are very derelict in this duty and are extremely loath to appear in any public way in defense of their own profession.

Several years ago I was delegated by our City Society to appear before a Legislative Committee in opposition to certain bills introduced by the anti-vaccinationists; the purport of the bills being to destroy all that had been accomplished in the way of compulsory vaccination requirements during the past years.

I told the members of the Society that I wanted some of them to go to Hartford with me. I did not ask them to say anything but simply to be there so I could point to them with pride as my supporters. I said I would do the talking. Several promised to be present. The State Board of Health sent out an appeal to the doctors to be present. How many do you suppose came? (A voice in the audience: "Three.") Correct, just three, the Commissioner of Health, the Health Officer of New Haven and myself.

The hearing was held in the room of the House of Representatives. The place was packed from top to bottom with anti-vaccinationists. They were well organized and their chief officers were a minister, a lawyer and a doctor. Their speakers were selected, were good ones and were well introduced by their toast master, the minister.

The hearing began at two o'clock and they were still going strong at 5 P. M. I was getting anxious.

I went to the Chairman of the Committee and asked him when he was going to give us a chance to speak. I said I wanted an opportunity to refute many of the outrageous statements the speakers had made. He said, "You don't need to do that, just keep quiet and let them talk. The matter is all settled now for the Committee has decided what it will do. These bills will not go through."

The Chairman of the Committee was a doctor and from information I obtained later I am sure he was largely instrumental in inducing his committee to report as it did.

I cite this case to show what even one doctor can accomplish provided he is alert to his opportunities.

We had a similar experience when we attempted to get a medical practice act adopted. We had a good bill, carefully drawn but only a handful of doctors were present to support it. The Osteopaths and the Chiropractors were there in droves. The Osteopaths had raised a fund of $1500 to fight the bill. It was defeated. Later when matters in the state became so notoriously rotten the lay public took the question in hand and we got a good bill passed.

Therefore, Mr. President and Gentlemen, I claim that we must educate the physician, we must educate the members of the profession themselves as to what their duties are and make them appreciate the necessity of taking advantage of every opportunity they may have of explaining to their patients and the public the truth regarding any question that may come up regarding their profession. In this way the attitude of the public on all medical matters will be a much more intelligent one and they will be better able to act in a manner conducive to their own good.

The next question is, how are we to accomplish this education of the members of our profession. It is a serious question and one which must be very carefully studied out. We have men in the profession who should they attempt to influence the public would act in the wrong way and so make matters worse rather than better.

We must remember that anything we do to improve and advance the practice of medicine is in reality for the benefit of the public.

Thank you, Mr. President and Mr. Secretary. I hope I have started something.

DR. BIRNIE: When Doctor Wheeler was talking about the hearing in Connecticut it reminded me of Massachusetts. I think possibly I can give an example. Some two years ago, we were to have a hearing on a certain bill in Boston and at that time I was a member of the Board of Registration in Medicine. I was asked to say a few words for the Board. We sat around in the room for half or three-quarters of an hour. Finally we started an investigation and we found that the hearing had been postponed for a week. We had to give up a whole day to go down to Boston to talk at that meeting and when we got there found that it was postponed. As Doctor Wheeler says, I also think that hearings have very little to do with the passage of a bill.

These matters of legislation are worked out outside of the Legislative Halls in a manner which we doctors do not understand, and the only way in which we may learn is to mix with the politicians and adopt their methods. In Massachusetts we have had practically no constructive legislation with regard to medical matters in the last ten years. Nearly everything that we have proposed has been defeated and nearly everything which we opposed has been passed. We do not know how to accomplish our ends. Possibly we must first instruct the public. When the public really becomes aroused and wants something it gets it. As I understand it, the Registration Bill in Connecticut was put

through by laymen and not by doctors, although it had the sanction of the medical profession. When the public of Connecticut became thoroughly aroused they stepped forward and demanded relief which was given them. We have had, in the past few months, in Massachusetts, meetings for the public in regard to cancer and tuberculosis and possibly some of you may have attended meetings of this sort. The attendance by the public was extremely small and possibly disheartening to the speakers, but I do not know as you can blame the public. Who wants to give an entire evening to some subject in which he is not particularly interested. The public is interested in medical matters only if it is personally affected. In addition, it is difficult to get a medical man to express himself in a form that is understandable and interesting to the laymen. I have been impressed by a number of articles published in the *Saturday Evening Post* written by "So and So" as told to "So and So." In other words, the story or facts are contributed by an authority but put into popular and interesting form by an expert writer. I know from my own personal experience when sitting waiting for dinner, if I see a short article in the newspaper which looks interesting I read it. In this way if the articles are authoritative, it is possible to absorb a considerable amount of knowledge at odd moments.

In order to get the public to read such articles on medical subjects, it is necessary to stress the interesting side rather than the scientific side, but the science can be there. It is almost impossible for a doctor to talk in ordinary lay terms, and scientific material does not interest the public. There must be some appeal. The medical facts may be furnished by medical authorities but the articles themselves should be handled by feature writers. I do not know just how this can be brought about but it seems to me that the thought may be worth something.

DR. ROWLEY: Education of the public with respect to legislation affecting medicine is a topic with which the profession has wrestled for many decades, and it is quite obvious that such work will have to continue so long as medicine and civilization shall continue.

Many phases of this problem have already been touched upon in the discussion here this afternoon. You will agree with me, I think, that it is fundamental that we should do everything in our power to help educate the public in medicine itself,—the advances made in the discovery of the causes of diseases and in their treatment and prevention.

From the point of view of the public, probably prevention of disease and illness occupies the front rank in both interest and importance. We all realize that a great deal has already been accomplished along this line, but much more remains to be done, and the thoroughness and judiciousness with which this work is carried on will be one of the biggest factors relating to medical legislation. When the public, including the legislators, fully understands what is best for its own good, the legislation that will help bring that about will surely follow, and the corollary is equally true that attempts on our part to foster legislative matters that are not clearly understood are almost sure to meet with failure until such time as the people become convinced that the movement is of vital importance to their welfare and is not some trick that the doctors are trying to put over in their own selfish interests.

There are different schools or types of practitioners of the healing arts, and not all think as we do, nor do they recognize the same facts revealed by science, and contradictions and denials from such sources have played their part in making the public slow to accept some of our recommendations as relates to health legislation.

The daily newspapers might be used more extensively than they have been in disseminating medical information with the censorship of the local medical societies. The frequent articles in the lay magazines and the wide distribution of *Hygeia* have no doubt accomplished much, and in time their influence and that of similar agencies will count for still more. Time, patience and perseverance must be had in carrying on a work of such magnitude.

In Hartford our local Medical Society has a Radio Committee that arranges for medical talks over the radio by some member of the Society. These talks are broadcasted through the courtesy of Station WTIC; are limited to ten minutes in length; are given once a week at the same hour; and cover the fall, winter and spring months. The speaker is required to submit in advance a written copy of his remarks to the Radio Committee for censorship. Through a more recent development the radio talk is printed in a local newspaper the following day.

This is mentioned as one more example of the right kind of publicity in medicine, and to what extent this is being carried on elsewhere I don't happen to know.

Another activity that is helpful in education of the public in medicine is the practice of some of our well informed members of accepting invitations to speak on some medical or health topic before social clubs, such as afternoon clubs for women and evening groups of men and women.

The combined influence of these several activities must have some effect in helping to shape public opinion, and we soon may count on another agency to work with us—and I believe that will be one of our very best allies; namely, the Woman's Auxiliary.

Another phase of this topic has been discussed; namely the individual co-öperation of physicians with respect to specific legislative matters. As Chairman of the Legislative Com-

mittee for our State Society for several years, I can frankly refer to my own experience as quite unsuccessful in the attempts made to have selected members of the Society present at the different hearings before the Legislature. It seems to me that the plan is a worthy one but its execution is miserable. However, we shall probably continue in our efforts along this line. One of the practical difficulties in connection with this is that the date for a hearing is sometimes changed at short notice and a physician from a distant part of the state will waste valuable time, or will have other plans which cannot easily be changed.

My own observation and experience in this field do not qualify me to offer any helpful suggestions, but I have been much interested in what I have heard here today, and believe that much help to all of us will come from such meetings, where our different experiences and plans are discussed.

PRESIDENT: We have here now the Secretary of the Board of Medical Registration of the State of Maine, Dr. Adam Leighton. He is very much interested in this subject, and I think he should give us a short discussion on his constructive ideas on this subject.

DR. LEIGHTON: *Mr. President and Members of the Maine Medical Association and Council*—"I have heard that certain action has been taken by the House of Delegates towards the settlement of this never ending question of legislation for the osteopaths. I understand that we as an Association, through the House of Delegates, and with the advice of the Council, have gone on record as favoring recognition of the osteopaths, and allowing for a composite board of medical examiners to be formed, in lieu of the present day Board of Registration of Medicine, and that said Board of Examiners should be composed of three osteopaths and three medical men! 50-50 representation! I can't understand the thing for a moment! We must be losing our senses, to go on record as being willing to drag ourselves down to the level of the cults of medicine. It is actual recognition of the osteopaths and we are placing the stamp of approval of the medical profession upon them through this action. I am told that a 'committee from this Association invited the Osteopaths' Committee on Legislation to meet with them and that as an outcome, we have been 'sold out to Raymond'!

Things have come to a poor pass. I have been told that 'the legislature of 1929 is favorable to the Osteopaths' and 'that they will get whatever they ask for'. Maybe so. They demand the right to practice surgery and obstetries and I suppose too, they will want to use drugs. Here we have men who called themselves 'drugless practitioners' a few years ago, trying to 'get into medicine through the back door' of Osteopathy. And we are a party to it!

I have come to the conclusion that probably it is poor business to journey to Augusta and fight these pseudo-medical cults every time a Legislature meets but I am not one who is willing to sit complacently by and let these fellows steal my rights and privileges of medical practice from me. There is too much of this 'let George do it' policy in our Association. There are hundreds of our members who don't know what is going on at the present time and here we go ahead and 'sell them out'.

Let us for once, get together and consider this question sensibly and be prepared to appear at the hearing in Augusta, and have a hand in this proposed legislative activity. The present Board of Registration of Medicine, of which I am proud to state I am a member, these past fourteen years, functions well. If the Osteopaths are to be given added rights and privileges of practice, let them have them if the Legislature sees fit, but let them administer them from their own Board of Osteopathic Examiners. Let's keep aloof and not emasculate the powers and rights of our own Medical Board by any particular alliance!

Keep the medical man and his practice separated from the Osteopath and the Chiropractor. Why should a band of ninety odd Osteopaths tell over a thousand medical men where we get off? That is the situation in Maine. We have been 'sold out' and if you don't watch out, in a few years we will be begging for the opportunity to continue the practice of medicine."

DR. SULLIVAN: I think we should decide at this meeting that we assure the Maine Medical Society that we will see that they are furnished with men to help them before the legislature next February.

Upon motion, duly seconded, it was

Voted—to assist the Maine Medical Association in providing men to help carry through the legislation.

PRESIDENT: What disposition do you wish to make of this discussion, and these papers this afternoon? Do you wish to have this report referred to the committee and have it report it at the next meeting, or what do you wish?

Upon motion, duly seconded, it was

Voted that the subject matter of this meeting be referred to a committee of three and that they report at the next meeting.

PRESIDENT: We will now have a report of the nominating committee for officers for the ensuing year:

President—Dr. James S. Stone.
Vice President—Dr. B. L. Bryant.
Secretary-Treasurer—Dr. W. P. Bowers.
Executive Committee—Dr. Stone, Dr. Parker, Dr. Hyatt.

DR. PARKER: It gives me great pleasure to have Dr. Stone elected president, because he has done more to bring this organization into being than any man, or three men, in New England.

Case Records
of the
Massachusetts General Hospital

ANTE-MORTEM AND POST-MORTEM RECORDS AS USED IN WEEKLY CLINICO-PATHOLOGICAL EXERCISES

EDITED BY R. C. CABOT, M.D.

F. M. PAINTER, A.B., ASSISTANT EDITOR

CASE 14351

FOUR YEARS' DYSPNEA IN A BOY OF SIXTEEN

MEDICAL DEPARTMENT

A sixteen-year-old schoolboy came to the Emergency Ward March 1 extremely ill.

The only history obtainable was that for four years he had had edema, dyspnea and orthopnea, following scarlet fever. For a year ending the June before admission he was in a hospital with an exacerbation of symptoms. During the summer he was in fairly good condition. For about a month before admission his symptoms had been growing progressively worse. For several weeks he had been in bed.

Clinical examination showed a fairly well developed and nourished boy lying propped up in bed, very dyspneic. Face pale and somewhat puffy. Lips cyanotic. Lung signs as shown in the diagram. Pulsation in the neck. Apex impulse of the heart felt diffuse and heaving, maximal in the sixth space 12.5 centimeters to the left of midsternum, 4.5 centimeters outside the midclavicular line. Left border of dullness 13 centimeters to the left, right border 7.5, supracardiac dullness 12 centimeters. Sounds loud, first sound at the apex accentuated, pulmonic second accentuated at the base. Rhythm absolutely irregular. Rate 100. At the apex a blowing systolic murmur and a low rumbling murmur throughout diastole. In the fourth left interspace by the sternum a slight early blowing diastolic. A slight systolic thrill and a questionable diastolic thrill in the fourth space just inside the nipple line. Blood pressure 170/70 to 90/60. An electrocardiogram showed auricular fibrillation, ventricular rate 100 to 110, right axis deviation, slurring Q R S. Abdomen somewhat tense, with rounded flanks. Dullness in the flanks, with marked fluid wave. Liver two fingerbreadths below the costal margin. Moderate edema of the hands, forearms, back and lower extremities.

Amount of urine not recorded, cloudy, specific gravity 1.018, a trace of albumin, bile positive; 0 to 3 leukocytes, occasional red cells, hyalin and finely granular casts at the single sediment examination. Blood not recorded.

Temperature 98° to 101.1°, rectal. Pulse 84 to 104. Respirations 22 to 28.

Nine hours after admission the patient suddenly became very cyanotic, with weak and slow respiration. The heart sounds were good. The blood pressure was 160/90. The chest was practically clear. He improved temporarily under morphia and caffein, but gradually relapsed. Venesection was done and 200 cubic centimeters of blood—all that could be obtained—withdrawn without effect. He died that afternoon of respiratory failure, the heart beating strongly to the end.

DISCUSSION

BY RICHARD C. CABOT, M.D.

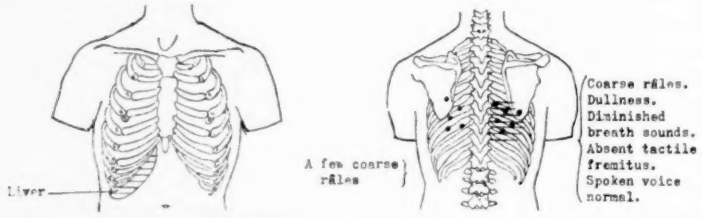
NOTES ON THE PHYSICAL EXAMINATION

From the diagram I should say there is evidence of edema of the lungs.

The right border, 7.5 centimeters, suggests a heart very big for his age. I have never heard of such a thing. I doubt its correctness.

The blood pressure is also queer.

The blood is not recorded, therefore there is probably no nephritis.



DIFFERENTIAL DIAGNOSIS

I suppose you will all say as I do, mitral stenosis. The only question is what else, if anything, is there? Of course, general passive congestion, ascites, probable hydrothorax, hydropericardium, edema of the lungs, nutmeg liver, etc. Slurring of the Q R S ordinarily means a myocardial lesion, but not necessarily anything that can be seen macroscopically. I do not venture to predict anything about this.

The main question is, did he have a pulmonary embolism? It is perfectly possible. The usual place for thrombi in mitral stenosis is the left auricle. But there might be some in the right ventricle too, and thence embolism in the lung.

A STUDENT: Could the death be due to acute passive congestion?

DR. CABOT: I suppose it could.

A STUDENT: What is the significance of the 12 centimeter supracardiac dullness?

DR. CABOT: I do not believe it was there. We have no X-rays of this case. They are the only answer to that question.

A STUDENT: He had a high blood pressure the first time and a history of scarlet fever. Do you think of progressive nephritis?

DR. CABOT: I do not know why his blood pressure is so high. There is not much said about the urine, and there were certainly a good many tests not made. I think he may have had nephritis. His face being puffy is another sign suggesting it.

A STUDENT: Is it common to get high blood pressure in fibrillating heart?

DR. CABOT: Blood pressure measurements with a fibrillating heart are almost worthless. You have to pick out certain beats and disregard the others.

CLINICAL DIAGNOSIS (FROM HOSPITAL RECORD)

Rheumatic heart disease with mitral stenosis and regurgitation and aortic regurgitation.
Adhesive pericarditis?
Congestive failure.

DR. RICHARD C. CABOT'S DIAGNOSIS

Rheumatic endocarditis, mitral stenosis.
Chronic passive congestion, general.
Perhaps pulmonary embolism.

ANATOMIC DIAGNOSES

1. *Primary disease.*

Subacute and chronic rheumatic heart disease.
Chronic rheumatic endocarditis of mitral and aortic valves with mitral stenosis and aortic regurgitation.
Subacute rheumatic endocarditis of mitral, tricuspid, aortic and pulmonary valves and of the auricular endocardium.
Subacute rheumatic myocarditis.

2. *Secondary or terminal lesions.*

Healed rheumatic pericarditis.
Hypertrophy of the heart.
Chronic passive congestion, general.

DR. TRACY B. MALLORY: This boy had an enormously enlarged heart, weighing 600 grams, a figure proportionately extremely high in view of his age. It was very interesting in showing rheumatic lesions of almost every possible variety. There was an old mitral stenosis and an old aortic regurgitation, also an old adhesive band in the pericardium about the apex of the heart. The base of the heart was entirely free. There were fresh rheumatic granules on the mitral, the tricuspid and the aortic valves, and even on the pulmonary. There were also fresh granules on the chordae tendiniae and on the auricular walls. The pericardium showed slight fibrous thickening and numerous focal collections of lymphocytes. In the adventitia of the smaller arterioles several small collections of endothelial leukocytes, fibroblasts and rare eosinophiles were found. These were typical of Aschoff granules in the healing stage. A few small areas of sclerosis were present.

The rest of the necropsy was entirely negative except for chronic passive congestion. The kidneys showed no nephritis.

DR. CABOT: Did you find any organisms in the heart valves?

DR. MALLORY: A staphylococcus aureus was found, undoubtedly a terminal infection only.

CASE 14352

ATYPICAL GALL-BLADDER SYMPTOMS AND THEIR EXPLANATION

SURGICAL DEPARTMENT

A married Syrian-American woman twenty-one years old entered August 4 complaining of pain in the right upper quadrant of one day's duration.

For five years she had had attacks of right upper quadrant pain, vomiting and chills at intervals of three or four months. During the past month she had had three such attacks, including the present one. The pain was localized in the right upper quadrant and radiated back to the left and down. The day before admission she vomited three times and had a movement of the bowels. The day of admission she had neither vomiting nor a movement.

Her family history is negative. She had always been well. She had slight dyspnea on exertion and rare headaches. She urinated once at night. She had recently lost weight.

Clinical examination showed an obese woman acutely ill, groaning with pain. The heart and lungs were not remarkable. The abdomen was obese, slightly distended, resonant. There was slight voluntary spasm in the upper abdomen and acute tenderness below the right costal border, and in a corresponding area to the left of midline. No peristaltic sounds were heard. The rest of the examination showed nothing of significance.

At the single urine examination before operation the amount is not recorded. The urine was cloudy, alkaline, not sufficient for a specific gravity test; sediment, one leukocyte per high power field. The leukocyte count was 20,000.

On the morning following admission there was no improvement in the patient's condition. There was a suggestion of icterus in the sclerae. She continued to complain of marked upper abdominal distress. She was moderately distended. There was definite tenderness in both the right and left epigastrium as well as in both flanks.

Before operation the temperature and respirations were normal, the pulse was 120.

August 5 operation was done. That night the patient was in moderate shock, relieved by intra-

venous saline and glucose. The pulse was rapid and of only fair quality. For the next three days she was very ill. The icteric index was 7. The stools showed bile, and at one of two examinations a strongly positive guaiac. August 10 she began to improve, the temperature and pulse to come down, the abdominal tenderness to lessen. There was much turbid yellow drainage. By August 20 the abdominal tenderness was all gone. The discharge grew steadily less. She continued to run a temperature of 100° to 101° and to vomit about once a day until she left the hospital September 17. The wound was then still discharging a little, and there was tenderness and a sense of resistance, possibly a mass, in the right upper quadrant.

Discussion

BY LELAND S. MC KITTRICK, M.D.

A history of definite attacks of severe right upper abdominal pain radiating through to the back is exceedingly suggestive of gall-stones, and with a negative urine is sufficient to warrant a tentative diagnosis. It would be difficult, however, to explain satisfactorily this patient's present condition on the basis of an uncomplicated cholelithiasis. The partial collapse, the tenderness across the upper abdomen—rather than a local tenderness in the gall-bladder region,—the presence of tenderness in the flanks, are all inconsistent with such a diagnosis. A leukocytosis of 20,000 is further evidence that there is some process present other than a gall-bladder with stones.

By the same reasoning it would be impossible to explain the present findings on the basis of a stone impacted in the cystic duct with resulting distention of the gall-bladder, either with or without infection. Here too the findings should be more localized unless leakage was present, and even in that case one would still expect most of the abdominal tenderness and resistance to be localized on the right side.

A perforated duodenal or gastric ulcer might give a picture of an acutely ill patient with a widespread tenderness, without much temperature elevation and with high pulse. Here again, however, it would be impossible to explain previous attacks of pain on this basis. Furthermore, the abdominal findings in an acute perforation of a duodenal ulcer should result in a more board-like abdomen with the point of greatest tenderness in the right upper abdomen, lessening as one goes down the right abdomen towards the pelvis and fading out in the left lower abdomen, unless the process had extended to a widespread peritonitis.

In every instance of symptoms suggesting gall-bladder disease, when the history and particularly the abdominal findings are not rationally explained by a simple gall-stone attack or by a stone impacted in the cystic duct with or without infection, the surgeon should have in mind a pancreatitis. The history of gall-bladder pain which, instead of quieting down as it usually does in cholelithiasis, is followed by intense distress across the upper abdomen and accompanied by definite tenderness along the course of the pancreas—particularly when it is associated with a slight or no elevation of temperature and a high white count—is sufficient evidence upon which to make a diagnosis of pancreatitis with or without gall-stones.

The presence of tenderness in both flanks means the presence of an irritating fluid in the abdomen. The most common irritating fluids in the abdomen are a purulent exudate, blood, or bile. The tenderness in both flanks of this patient presupposes a widespread distribution of the fluid. The history and other physical findings are not compatible with extensive purulent peritonitis. Bloody fluid, nearly always present in the hemorrhagic type of acute pancreatitis, would adequately fit in with the history and physical findings of this patient, and offers a satisfactory explanation for the tenderness.

A logical and reasonable diagnosis in this case is, therefore, acute hemorrhagic pancreatitis with or without gall-stones.

PRE-OPERATIVE DIAGNOSIS

Acute hemorrhagic pancreatitis.
Cholelithiasis.

OPERATION

Gas-ether. Right rectus upper abdominal incision. On opening the abdomen there was a moderate amount of blood stained fluid. There were extensive areas of fat necrosis in the omentum, mesentery and peritoneum. In the areolar tissue around the transverse colon there was a large hemorrhagic area. The pancreas was markedly enlarged, purplish, and seemed to be involved throughout most of its extent. The gall-bladder was small, edematous, dark in color, moderately distended and filled with fairly small stones. The gall-bladder was opened, the stones removed and a tube tied in place. An opening was then made in the pancreas above the stomach and a cigarette wick inserted. A cigarette wick was placed to the foramen of Winslow.

POSTOPERATIVE DIAGNOSIS

Acute hemorrhagic pancreatitis.
Cholelithiasis.

Further Discussion

In this instance the extensive necrosis present made it seem advisable to drain the pancreatic capsule. The relief from pain following this procedure is usually striking. It is always desirable, particularly if there is any possibility of obstruction to the outflow of bile from the common duct, to drain the biliary system. Therefore this patient had those procedures done

which offered the greatest relief in this type of lesion.

Her postoperative course was not atypical of the more serious cases of these patients who survive the disease. The patients are apt to be desperately sick for awhile; drainage from the pancreas may continue for an indefinite period of time, it is exceedingly difficult to make them eat, and nausea is very apt to continue for ten days or two weeks, sometimes more. At times there may be a temporary period following the operation when the appetite is fairly good and the intake of fluid and nourishment reasonable. Even these patients may become nauseated at the end of a week and for days find it exceedingly difficult to take nourishment. In spite of the fact that a large portion of the pancreas may slough out it is only rarely that sugar appears in the urine.

It is reasonable to suppose that the ultimate result with this patient will be good.

LATER NOTE

April 28, seven months after her discharge, the patient reported. The wound was solid,—no symptoms. She was four months pregnant.

DIAGNOSIS

Acute hemorrhagic pancreatitis.
Cholelithiasis.

PROMOTION OF HEALTH IN RURAL SCHOOLS

The chief of the Division of Physical Education and School Hygiene of the Bureau of Education, James F. Rogers, has listed the necessary steps in the promotion of health in rural schools. The article in whole appeared in *School Life* in June, 1928. The steps are:

1. The desire to make health a real, as well as a theoretical, objective in education.
2. The stimulus and direction of health work coming from an individual, such as the county or district superintendent or supervisor, or the principal. The interest and co-öperation of the board of education is essential.
3. Understanding by the parents of the school's objective. This may be furthered by the distribution of suitable literature such as is prepared by the Bureau of Education.
4. Utilization of existing agencies such as the State Department of Education, State Department of Health, county or district public health organizations, etc.
5. Needed changes in the school plant of a physical nature.
6. Health examinations.
7. Health education.
8. The solving of nutritional problems by the institution of school lunches, etc.
9. Physical education — the playground — supervised play and exercise.
10. The enlistment of special workers and the inauguration of special classes.

COAL-MINE FATALITIES IN AUGUST

Accidents in coal mines in the United States in August caused the death of 167 men, according to reports received from State mine inspectors by the United States Bureau of Mines, Department of Commerce. Thirty-three of these accidents occurred in the anthracite mines of Pennsylvania; the remaining 134 were in bituminous mines in various States. The death rate per million tons of coal produced during the month was 3.48 based on an output of 47,991,000 tons; the rate for August a year ago was the same, based on 49,399,000 tons and 172 deaths. The death rate for bituminous coal alone for August, 1928, was 3.26 with 41,108,000 tons and 134 fatalities, and that for anthracite was 4.79, with a tonnage of 6,883,000, as compared with rates of 3.50 and 3.38, respectively, for August of last year, based on a production of 41,705,000 tons and 146 fatalities for bituminous, and 7,694,000 tons and 26 fatalities for anthracite. Thus, while the fatality rate for the industry as a whole was the same for August of both years, the bituminous rate for the current month shows a slight decrease while that for anthracite is somewhat greater than for August, 1927.

Reports furnished the Bureau of Mines for the first eight months of 1928 show that accidents at coal mines caused the loss of 1,429 lives as compared with 1,536 for the same period in 1927. The production of coal thus far in 1928 is 360,134,000 tons, showing a fatality rate of 3.97 per million tons of coal produced; that for January to August, 1927, was 405,274,000 tons with a fatality rate of 3.79.—*Department of Commerce, Washington.*

WEEKLY HEALTH INDEX

SUMMARY

Telegraphic returns from 70 cities with a total population of thirty-one million for the week ending August 11 indicate a mortality rate of 11.7 as against 10.4 for the corresponding week of last year. The highest rate (18.7) appears for San Antonio, Tex., and the lowest (5.7) for Lowell, Mass. The highest infant mortality rate (187) appears for Duluth, Minn., and the lowest for Tacoma, Wash., which reported no infant mortality.

The annual rate for 70 cities is 13.5 for the thirty-two weeks of 1928, as against a rate of 12.7 for the corresponding weeks of 1927.

MEDICAL TESTS OF STUDENTS COMPULSORY IN FORTY-TWO STATES

Forty-two States have medical inspection laws, according to a summary of educational medicine published in the September *School Life*, issued by the Bureau of Education. The full text of the statement follows:

Forty-two States have medical inspection laws of some kind. In 16 of the States medical examination is mandatory for pupils in all school districts. Examinations are given in 23 States by specially trained persons — physicians or nurses, physical directors, dentists, or some combination of these. In 13 States examinations may be given by the teacher; in two States by the superintendent, principal, or teacher.—*U. S. Daily.*

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ANTIGENS AND HAPTENS

IN the whole realm of immunology there are no elements of greater importance than antigens. In fact the whole philosophic structure as well as all the practical applications of this science depend upon the series of physiologic changes that follow the introduction into the body of alien proteins and upon the various reactions which subsequently take place when these antigens come into contact with the tissues of a body into which the same antigen had previously been introduced.

Recent chemical and serologic studies have done much to clarify our knowledge of the nature and action of this class of substances, and not only must we modify some of our earlier views but we must change some of the familiar terms and differentiate between the elements that generate antibodies and the elements that react with antibodies. It now seems certain that the only substances that are capable of stimulating body cells to the production of specific immune or antibodies are proteins. Pure carbohydrates, pure lipins or lipoids alone are inert in this regard, although when existing in combination with proteins they share in the antigenic effect, and the effect is quite different from that of the protein alone. Avery and Heidelberger have chemically dissected pneumococci and have shown that their protein moiety gives rise to antibodies which are common to the species but not specific for type. There is also a carbohydrate fraction, which on the other hand, produces no antibodies by itself.

When intact pneumococci—that is pneumococcus substance in which the combination between protein and carbohydrate is unbroken—are injected into the animal body, antibodies strictly specific for the type injected are produced. Furthermore, it is the carbohydrate that is the specific reacting substance when pneumococci are brought into the presence of homologous immune serum. We have here then a sharp differentiation of antigenic action into two functions. The first function is to generate immune or antibodies and the second is to combine with these bodies. Some substances may possess both characters, some only one of the two, and, therefore, we need to make a finer distinction between these functions. The same is true in the case of the familiar Wassermann test. Wassermann, to cite what is the most pertinent and illustrative example, in developing the Bordet-Gengou phenomenon of complement fixation as a test for the diagnosis of syphilis, proceeded on the hypothesis that since it was the Treponema pallidum that gives rise to specific antibodies in the blood of the syphilitic patient, he must employ some suspension or extract of the Treponema to detect this syphilitic antibody. It being impossible then to cultivate these spirochaetes, he used watery, then alcoholic extracts of the livers of luetic foetuses as his "antigen." Then, because of the scarcity of such material, some one found that normal livers would do as well. Later it was discovered that heart muscle or other muscles contained some chemical component or components that would combine with the syphilitic antibody and bind complement quite as specifically and completely as would Treponema extracts. This discovery appeared at first to be upsetting to the Ehrlich theory and to immunologic ideas in general. Here some substance in apparently no way related to syphilitic processes gave a reaction specific for syphilis, but in what, according to our theoretical conception, must be a non-specific way. Since then the contributions of Forsmann and of Landsteiner, have shown that the generating substance or antigen and the reacting or combining substance are not necessarily the same, hence the term "antigen" may be a misnomer when applied to the latter.

From every standpoint, therefore, it seems to be desirable to give these two classes of substances different and distinguishing names. The term "antigen" then, should be applied only to those substances which give rise to the formation of immune or antibodies, and for the sub-

stances which combine with antibodies, Landsteiner has proposed the name "hapten." This change would make for scientific accuracy. Under it, toxins, vaccines, all substance or material used for the production of active immunity would be classed as "antigens," and the so-called Wassermann, Kahn or Hinton "antigens" and all substances causing specific reactions with immune serums, such as agglutination, flocculation, complement fixation, and antitoxin neutralization, as well as such somatic phenomena as anaphylaxis, would be called "haptens." The corresponding adjectives would be "antigenic" and "haptenic." This JOURNAL joins in recommending the adoption of this differentiation and of the new name "hapten."

LABORATORY ANIMALS

OCCASIONALLY in the past, and unfortunately even at the present time, errors in experimental work have been permitted to creep in through ignorance of the abnormal conditions in the animals used for experimentation. Unfortunately in many laboratories a guinea pig is still a guinea pig, and rabbit still a rabbit in spite of various diseases that may be present and embarrassing to the course of the work planned. We have learned to be meticulous in the selection of glassware or chemicals, but we have paid little attention to the complicating factors that may be introduced by existent or intercurrent diseases in the laboratory animals.

While there is much scattered information on the subject it is only recently that it has been available. One of the best reviews of the subject is that of Meyer.[1] Recently Webster[2] and others have made use of epizoötics in laboratory animals to further their knowledge of epidemiology.

The susceptibility of any animal to laboratory infections pre-supposes that it must be liable to a number of spontaneous infections, and it is of utmost importance that these be recognized and proper allowance made. So far as the guinea pig is concerned the "paratyphoid" infections and the septicemias due to the organisms of the Pasteurella group are the most important. In the rabbit, on the other hand, the respiratory diseases are most common, particularly snuffles. The epidemics of snuffles among rabbits have been carefully studied by Webster.[3] The various studies have brought out that the carrier problem is just as serious in laboratory animals as it is among humans.

Once recognized, the many and varied spontaneous infections of laboratory animals are an advantage as well as a liability in that they afford excellent material for epidemiologic studies. With the short-lived laboratory animals such problems as racial and hereditary immunity are far more rapidly susceptible of solution than in the case of the human population. However, failure to become familiar with the problems of comparative pathology and bacteriology of the laboratory animals may well lead in the future, as it has in the past, to serious errors in the interpretation of laboratory results.

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2 Webster, L. T.: Am. Jour. Hyg., 4, 134, 1924.
3 Webster, L. T.: Jour. Exper. Med., 45, 529, 1927.

DR. COFFEE SEES IT THROUGH

DR. W. O. COFFEE, of Davenport, Iowa, the eminent ear specialist and originator of the Dr. Coffee treatment for nasal catarrh and catarrhal deafness, entirely safe and harmless and praised by thousands of users, is not going to allow his patients to suffer from progressive deafness and increasing head noises because of a matter of mere finances. No indeed! To those who have once written him that they suffered from nasal catarrh, catarrhal deafness and head noises and received a free trial of his medicines, but did not come across with the full $30.00 course of treatment he now offers the same three months treatment for only $5.00, which is a substantial reduction, and all in the interests of humanity.

This offer, in fact, is even more generous. If three months treatment does not dry up the catarrh, restore the hearing and remove the head noises, (which is unthinkable since the results of the treatment, worked out and perfected in over 45 years of constant practice, have been carefully watched in thousands and thousands of cases) another three months treatment will be given entirely free or the money will be refunded!

Dr. Coffee is apparently a man of an expansive and generous nature. His picture, printed on his letterhead, (not the one with the beard, of twenty years ago) shows that he must be written as one who loves his fellow men. Dr. Coffee is quite disturbed over the possible unfortunate results of deafness. On the modest pink sheet accompanying his letter, a trifling reminder, 21 by 18½ inches in size with only 3½ inch capitals at the top, are various artistic reminders of the probable fate of the deaf—or at least of those who have neglected his treatment. In the large circle a very attractive, although deaf young woman is being smitten by a locomotive. The boiler is striking her in the region of the head of the left tibia, and she is about to fall under the wheels. Her market basket seems to be a total loss. Below her a young man seems to be taking a nap against the front of a swiftly moving trolley car. At the right is a hazy, impressionistic view of a room in the casualty ward. A motor car claims its victim above. A well dressed young man at a musical comedy fails to catch the salacious remark over which his fair companion is chortling. Other apt illustrations are present, but we would not bore our readers.

A year or so ago Dr. Coffee, with the kindly intention of banishing deafness from New England, hired, for this purpose, a whole page in the *Boston Post* and paid for it out of his own pocket. Such generosity should not go unrewarded. Should not the Propaganda for Reform Department of the American Medical Association take cognizance of Dr. Coffee's altruistic activities, if they have not recently done so?

THE VISITING SURGEONS

Boston, after an interim of six years, has again been host to the surgeons of the World, who have been attending the sessions of the American College of Surgeons through the week beginning October 8, 1928.

The reputation of the local surgeons and hospitals has always been powerful in drawing large numbers of leading men in the profession to this city because the traditions of the past have been equalled by the achievements of the present in advancing and maintaining scientific medicine.

The social features have competed with the scientific displays and discussions in furnishing the greatest possible range of entertainments. The hospitals and section meetings have demonstrated remarkable concentration on the problems inherent in dealing with human ills.

The orations by distinguished representatives of other countries were of excellent quality. The addresses of the officers of the College reflected broad conceptions of the functions of the organization and the spirit of its members.

It was a pleasure to meet our distinguished fellow worker in medical literature Sir Squire Sprigge, M.A., M.D., B.Ch., F.R.C.S., for many years the Editor of the *Lancet*, who in delivering the Hunterian Oration portrayed a little known and more intimate aspect of the life of John Hunter. Hunter's intense interest in all phases of animal life, his great activity of mind and hand, his ability to derive useful knowledge from any phenomenon in natural history, justified the lecturer in selecting as a title "Grand Curiosity".

An especially interesting feature was the session of the Boston Surgical Society which was convened on the evening of October 10 to do honor to Dr. Chevalier Jackson of Philadelphia, Pa., by conferring the Henry J. Bigelow Medal. Further details of this occasion appear on page 758 of this issue.

The exercises commemorating the demonstration of the anaesthetic properties of sulphuric ether in the Massachusetts General Hospital were impressive and brought together many local and visiting surgeons as well as officers of the hospital organization and lay friends. The paper of Dr. Graham Lusk with introductory remarks by Dr. Joslin and the presentation speech of Dr. McMechan will appear in the issue of October 25.

The Officers of the College and the Committee of Arrangements are to be congratulated on the excellence of the program and management of details.

The election of Major General Ireland to the Presidency will insure progress in the future activities of the College.

The spirit pervading the meetings was that of optimism in the future development of knowledge relating to human ills and the best possible application of that understanding in bringing about prevention and cure of disease.

We trust that our visitors have been convinced of the most cordial appreciation of the honor conferred by their presence and that Boston may be considered to be one of the resources of the American College of Surgeons in arranging for future meetings. We also hope that our visitors may always feel that members of the College are welcome in the meetings and homes of brother fellows in this section.

THIS WEEK'S ISSUE

Contains articles by the following named authors:

Jackson, Chevalier. Sc.D., M.D., Jefferson Medical College, 1886, F.A.C.S. Professor of Bronchoscopy and Esophagoscopy, Jefferson Medical College and University of Pennsylvania Graduate School of Medicine; Bronchoscopist, Jefferson Medical College Hospital, University of Pennsylvania Hospital; Lecturer in Bronchoscopy and Esophagoscopy, Women's Medical College and Temple University. His subject is: "Bronchoscopy: Past, Present and Future". Page 759. Address: 128 South Tenth Street, Philadelphia, Pennsylvania.

Dayton, Neil A. M.D. Ohio State University, 1915. Director, Division of Mental Deficiency and Division of Research, Massachusetts Department of Mental Diseases. Member, Massachusetts Psychiatric Society, New England Society of Psychiatry, American Psychiatric Association, American Association for Study of Feeble Minded, American Statistical Association. Address: Room 109, State House, Boston. Associated with him is:

Dolan, Helen H. S.B. Simmons College. Chief Research Worker, Massachusetts Department of Mental Diseases. Their subject is: "The Trend in Legal Form Used in Admitting Patients to the Danvers State Hospital". Page 764. Address: Room 109, State House, Boston.

Fitchet, S. M. A.B., M.D. Harvard, 1921; B.P.H. Harvard, 1923, F.A.C.S. Junior Assistant Surgeon, Children's Hospital; Assistant in Surgery, Massachusetts General Hospital; Associate Surgeon, Baptist Hospital; Assistant in Orthopedic Surgery, Courses for Graduates, Harvard. His subject is: "Fistula an Etiological Factor in Rectal Carcinoma". Page

766. Address: 270 Commonwealth Avenue, Boston.

RUSHMORE, STEPHEN. B.A., M.D. Johns Hopkins, 1902, F.A.C.S. Surgeon, Massachusetts Women's Hospital, Boston; Consulting Gynecologist, Symmes Arlington Hospital; Surgeon, Gynecological Department, Boston Dispensary. His subject is: "Nursing and Maternal Welfare". Page 768. Address: 520 Commonwealth Avenue, Boston.

LORD, FREDERICK T. A.B., M.D. Harvard, 1900; Visiting Physician, Massachusetts General Hospital; Faculty Instructor in Clinical Medicine, Harvard Medical School; Member Association of American Physicians; American Society for Clinical Investigation; American Society for Thoracic Surgery. His subject is: "The Diagnostic Value of Cholecystography". Page 773. Address: 305 Beacon Street, Boston.

DANA, HAROLD W. A.B., M.D. Harvard, 1905. F.A.C.P. Assistant Professor of Theory and Practice of Medicine, Tufts Medical School. Assistant Visiting Physician, Boston City Hospital. His subject is: "The Effect of Lateral Posture in the Examination of the Chest". Page 774. Address: 429 Beacon Street, Boston.

O'BRIEN, THOMAS J. Ph.G., M.D. Harvard, 1899. Associate Professor of Medicine, Tufts College Medical School; Assistant Visiting Physician to the Boston City Hospital; Formerly Vice-President of the Massachusetts Medical Society. His subject is: "Education of the Public with Respect to the Cults". Page 777. Address: 501 Beacon Street, Boston.

RICKER, WILLIAM G. M.D. Johns Hopkins, 1904. Secretary of the Vermont State Medical Society. His subject is: "Education of the Public with Respect to Public Health Problems". Page 782. Address: St. Johnsbury, Vermont.

THE BOSTON MEDICAL LIBRARY

CLIMATOLOGY

IT is interesting to note the passing of the use of the above term to represent a therapeutic concept. Not so many years ago there were Chairs in some of our Medical Schools for the furthering of knowledge of the advantages of climate for particular diseases. Either climate has been proven to be less efficacious than it was supposed to be or other methods of treatment are superior to it, or the transference of patients to remote localities where climatic advantages might be obtainable has entailed an isolation that is so prejudicial to the well-being of the sufferer that any advantage that might accrue because of climatic change has been negatived. Whatever the cause may be the fact remains that we hear much less about sending tuberculous subjects to the far west and arthritic patients to dry climates than formerly. Not that it is not still done but it is now considered less of a necessity. If the truth were known there are probably a number of reasons why this has been the case, all of which ignore the specific value of climatic advantage. In other words climate still holds the key to a therapeutic door of considerable advantage for many patients but fashion and other interests have temporarily discouraged its use. From the very earliest times physicians have recognized the advantages belonging to an equable climate. The Temples of Aesclepiadae were located with particular reference to such advantages. Salernum and Montpelier were renowned for their salubrious climate. Freedom from sudden variations in temperature, protection from winds that are chilling, habitually low moisture content in the air, great preponderance of sunshine, lack of dust and smoke contamination in the atmosphere having a direct bearing upon the efficacy of the Sun's rays, an elevation above sea level which imposes no undue burden upon cardiac and respiratory activities and natural facilities for various forms of hydrotherapy—these are some of the distinctive benefits to be secured which are of conspicuous benefit in the management of certain conditions. Artificial sun light, helioglass, Finsen light, thermo light, violet ray, radium, X-ray and other forms of supposedly therapeutic ray are only a substitute, and a very indifferent substitute, for the above mentioned natural agencies. Discovery of certain properties of light, heat and electricity have resulted in their being harnessed up for therapeutic purposes. The idea that such measures could be applied at home with a minimal loss of time and expenditure of effort has probably been one of the important reasons why we do not hear so much about the advantages of climate. We desire to "get rich quick" and, by the same token, we desire to "get well quick", hence all the therapeutic short cuts that are being exploited to satisfy this demand for immediate results. Knowledge of the specific advantages of climatic change is not something to be brushed aside or forgotten. In the appropriate circumstances it is probably as important a sort of information to possess as it is to be conversant with the art of dietetics. The skillful physician will possess himself of such knowledge and will apply it discriminatingly where there are indications for its use.

We have been forgetting something because of the glamour of the new lights that constitute the bulk of modern physiotherapy. These have their places and merit study but are not necessarily an improvement upon what Nature has already provided. After the present exhibition of literature on Arthritis has been returned to the shelves on October 27th some of the more important literature on Climatology will be exhibited in Holmes Hall.

MISCELLANY

RÉSUMÉ OF COMMUNICABLE DISEASES IN MASSACHUSETTS

SEPTEMBER, 1928

GENERAL PREVALENCE

The total reported incidence of communicable diseases for September was the lowest for that month since 1914.

The incidence of anterior poliomyelitis was high.

The reported incidence of chickenpox, lobar pneumonia and scarlet fever was within endemic limits.

The reported incidence of German measles, measles, mumps and whooping cough was low.

A new low record for September was reached in the incidence of diphtheria and typhoid fever.

RARE DISEASES

Actinomycosis was reported from Boston, 1; total, 1.

Anterior poliomyelitis was reported from Ashby, 1; Athol, 5; Attleboro, 1; Bernardston, 2; Beverly, 2; Bridgewater, 1; Boston, 18; Brockton, 1; Cambridge, 4; Dedham, 1; Dalton, 1; Dartmouth, 1; Fall River, 6; Fitchburg, 2; Great Barrington, 1; Hamilton, 1; Haverhill, 1; Hingham, 1; Hatfield, 1; Lawrence, 1; Lowell, 1; Lynn, 1; Lenox, 1; Marblehead, 1; Milton, 1; Needham, 1; Newton, 7; North Adams, 1; Pittsfield, 10; Revere, 2; Southwick, 1; Salem, 3; Somerville, 3; Springfield, 2; Stockbridge, 1; Shrewsbury, 1; Stoughton, 1; Taunton, 2; Walpole, 3; Waltham, 7; Watertown, 13; Wendell, 1; Weymouth, 1; Winchester, 1; Worcester, 2; total, 120.

Dog-bite requiring anti-rabic treatment was reported from Arlington, 1; Boston, 9; Braintree, 2; Chelmsford, 3; Holyoke, 1; Lowell, 12; Malden, 4; Mansfield, 1; Medford, 2; Newton, 1; Pittsfield, 1; Revere, 9; Taunton, 1; Winthrop, 1; Woburn, 2; total, 50.

Dysentery was reported from Boston, 2; Fall River, 1; Worcester, 5; total, 8.

Encephalitis lethargica was reported from Boston, 1; Framingham, 1; Lynn, 1; Marlboro, 1; Methuen, 1; Saugus, 1; Worcester, 2; total, 8.

Epidemic cerebrospinal meningitis was reported from Boston, 1; Middleboro, 1; North Adams, 1; Orange, 1; Worcester, 1; total, 5.

Malaria was reported from Boston, 1; Brockton, 1; Holyoke, 1; total, 3.

Pellagra was reported from Boston, 1; Bridgewater, 1; total, 2.

Rabies was reported from Newton, 1; total, 1.

Septic sore throat was reported from Amesbury, 1; Boston, 6; Dracut, 1; Everett, 1; Gill, 1; Lee, 1; Lynn, 1; Malden, 1; Marion, 1; Northampton, 1; Quincy, 1; Shirley, 1; Wakefield, 1; total, 18.

Tetanus was reported from Boston, 1; Greenfield, 1; New Bedford, 1; North Adams, 2; Pittsfield, 1; Rockland, 1; Springfield, 1; total, 8.

Trachoma was reported from Boston, 3; Easthampton, 1; total, 4.

MONTHLY REPORT OF CERTAIN COMMUNICABLE DISEASES.

DISEASE	Cases in Entire Population Sept. 1928	Sept. 1927	Prosodemic Index	Epidemic Index	Case Rates per 100,000 Pop. Sept. 1928	Sept. 1927	Expected Rate***
ALL CAUSES	2,510	3,313	-	-	58.0	77.6	-
Ant. Poliomyelitis	120	373	92*	1.3**	2.8	8.7	2.1
Diphtheria	157	291	331*	.5**	3.6	6.8	7.7
Measles	157	151	259*	.6**	3.6	3.5	6.0
Pneumonia, Lobar	99	155	118*	.8**	2.3	3.6	2.7
Scarlet Fever	316	432	368*	.9**	7.3	10.1	8.5
Tuberculosis, Pul.	324	384	357*	.9**	7.5	9.0	8.3
Typhoid Fever	43	82	83*	.5**	1.0	1.9	1.9
Whooping Cough	264	397	542*	.5**	6.1	9.3	12.5
Chicken Pox	97	78	-	-	2.2	1.8	-
German Measles	17	24	-	-	.4	.6	-
Influenza	26	20	-	-	.6	.5	-
Mumps	74	116	-	-	1.7	2.7	-
Tuberculosis, O. F.	48	72	-	-	1.1	1.7	-

* This Index is an attempt to estimate the number of cases based on the trend during the past years which can be expected to occur, and is for the purpose of comparison with the number of cases which actually did occur.

** This ratio expresses how prevalent the disease is compared with the index mentioned above; 1.0 indicates that the actual number of cases equals the expected number. A larger number means a greater prevalence, and a smaller number a lesser prevalence than expected. Thus, 2.0 would indicate twice the expected number of cases, and .5 half the expected number of cases. The method used to determine the indices is described in the August 18, 1927 issue of the Boston Medical and Surgical Journal.

*** Calculated from the Prosodemic Index.

FORTHCOMING REPORT ON THE SAUNDERS AWARDS

The offer of two prizes of $50,000 each by Mr. William Lawrence Saunders for an effective means of preventing and curing cancer expired on February 1, 1928. All of the applications, numbering 3,529 up to May 1, have been placed before the Board of Reference consisting of a group of eminent medical men which the American Society for the Control of Cancer requested to act for it in an advisory capacity. At a recent meeting of this Board held at Washington, D. C., the following report was made:

"1. None of the proposals submitted up to February 1, 1928 is worthy of an award either for the prevention or cure of cancer.

"2. While it is to be regretted that no effective preventive or curative agent has been discovered as a result of the offer of these awards, it is the opinion of the Board that a great amount of material has been accumulated, the analysis of which, if published, would be of great value to medical science.

"3. It is recommended, therefore, that a report be prepared by the American Society for the Control of Cancer upon analysis of these applications in order that the information thus acquired may be placed permanently on record, together with such statement of the facts now established in regard to cancer as will serve to explain why the remedies advocated do not, and could not be expected to, serve as an effective preventive or curative agent.

"4. This report should be prepared for publication primarily for the medical profession, but the facts should also be made accessible to the general public."

The foregoing report has been ratified by the Executive Committee of the Society and steps are now being taken to prepare such a report as the Board of Reference has recommended. Mr. Saunders is warmly in favor of producing a volume which shall express in readily understandable language the essential facts and opinions as proposed by the Board.—*Bulletin American Society of the Control of Cancer.*

CORRESPONDENCE

TESTIMONY WITH RESPECT TO INSURANCE

October 11, 1928.

NEW ENGLAND JOURNAL OF MEDICINE:

When the Massachusetts Medical Society approved the policy of the United States Fidelity & Guaranty Company, I changed my liability coverage to them.

I have had only one occasion to ask service on the part of the company, a case of rather minor importance but one of the kind which carries with it a certain amount of personal worry no matter how absurd the complaint, and which has been satisfactorily cared for very promptly after having been reported to the company's representative, Mr. George H. Crosbie.

I feel that it would be beneficial for the members of the State Society to give loyal support to the company which has undertaken their protection, and that a great advantage could come from unified effort.

Very truly yours,
W. D. ROWLAND.

DR. PRATT REAFFIRMS HIS POSITION

October 3, 1928.

Editor, N. E. JOURNAL OF MEDICINE:

Evidently my letter in the JOURNAL of August 2nd which was written because of a statement in a recent issue of the JOURNAL by a member of the Society, that both the United States Fidelity and Guaranty Company and the Medical Protective Company were on an equal par, has started a discussion.

The Medical Protective Company has attempted to refute my statements by writing directly to all members of the Society. I do not propose to be drawn into a discussion with any insurance company, particularly with the Medical Protective Company.

Being in a position to judge the relative merits of both companies, as I was insured in both at the time of my claim, I felt duty bound to the members of my profession to provide them with the benefit of my experience to controvert the statement made.

I am not interested in any insurance company or its agents, but I am vitally interested in my own affairs and that of my fellow members. If this discussion will save any member of my society from a similar experience, I feel that I have accomplished my purpose. I wish to assure you that had the position been reversed, I would have been equally frank in my statement of the service rendered.

I am glad that I have "the privilege of choosing" my own protection.

Yours very truly,
EZEKIEL PRATT.

RECENT DEATHS

HASKINS—DR. SOLOMON FOOT HASKINS, a retired Fellow of the Massachusetts Medical Society, died at the Cape Cod Hospital, Hyannis, October 4, 1928, of coronary and cerebral thrombosis, at the age of 70 years.

The son of Henry and Susan Powers Haskins, he was born at North Prescott, Mass., September 8, 1858. His education was in the public schools and at Dartmouth Medical School, where he received his M.D. in 1880. The following year he settled in Yarmouth, Mass., and joined the State medical society, moving to Orange, Mass., in 1888, and to Cotuit in 1895 and practising in the last named place until shortly before his death.

He devoted much attention to ophthalmology though doing a general practice. He is survived by his widow, who was Miss Grace Childs Baker, and by a son and a daughter.

Dr. Haskins was a thirty-second degree Mason.

PARKER—DR. WALLACE ASAHEL PARKER is reported to have died at his home in Auburn, Mass., of cerebral embolism, May 26, 1928, at the age of 64.

He was a graduate of the University of Michigan Medical School in 1892, settled in Springfield, Mass., the following year and joined the Massachusetts Medical Society. For fifteen years after 1898 he left the society. Rejoining from Medford, in 1913 he practised in the following places in the order named: Bethlehem, N. H., Bartlett, N. H., Gorham, N. H., Dighton, Charlestown, Manchaug, Charlemont, Mass., Lisbon, N. H., Dorchester, Fiskdale, Auburn, Charlestown, Becket and Auburn, Mass.

NEWS ITEMS

HARVARD MEDICAL SCHOOL NEWS

Registration figures for the Harvard Medical School, 1928-'29, according to the Dean's office are: Fourth year, 135; third year, 137; second year, 118; first year, 125; total, 515. No graduate or special students are enrolled.

Professor H. H. Dale, Director of Research at the National Institute for Medical Research, Hampstead, London, will lecture on Friday, October 19, 1928, at 5 P. M. in Building C amphitheatre. The lecture is open to the medical profession, medical students, and others who may be interested.

The following appointments were made for one year from September 1, 1928, according to information received from the Dean's Office:

John Seward Lawrence, M.D., Instructor in Medicine.

Reuben Zeiten Schulz, M.D., Instructor in Pathology.

Edward Lorraine Young, Jr., M.D., Instructor in Surgery.

Carmi Rupert Alden, M.D., Assistant in Gynaecology.

Pierce James Dunphy, M.D., Assistant in Gynaecology.

Abraham Solomon Troupin, M.D., Assistant in Gynaecology.

Theodore Lasater Terry, M.D., Assistant in Ophthalmology.

Lawrence Henry Sophian, M.D., Assistant in Pathology.

John Ignatius Bradley, M.D., Assistant in Pathology.

Fletcher Hatch Colby, M.D., Assistant in Genito-Urinary Surgery.

Robert Ritchie Linton, M.D., Alumni Assistant in Surgery.

Tracy Jackson Putnam, M.D., Assistant in Surgery and Research Fellow in Neuropathology.

Edward Parnall, A.M., Teaching Fellow in Anatomy.

George Allen Bennett, A.B., Teaching Fellow in Histology.

William James Gardiner, M.D., Teaching Fellow in Medicine.

George Elwood Nesche, M.D., Teaching Fellow in Medicine.

Maxwell Finland, M.D., Charles Follen Folsom Teaching Fellow in Hygiene.

Jayme Arcoverde Cavalcanti, M.D., Research Fellow in Biological Chemistry.

Stephen James Maddock, M.D., Research Fellow in Biological Chemistry.

Max Hochrein, M.D., Research Fellow in Physical Chemistry.

Francis John Worsley Roughton, Ph.D., Research Fellow in Physical Chemistry.

Albert Victor Neale, M.D., M.R.C.P., Research Fellow in Pediatrics.

Bert Cunningham, Ph.D., Research Fellow in Physiology.

Marcel Florkin, M.D., Research Fellow in Physiology and in Physical Chemistry.

Margaretha Antoinette Ribble, M.D., Research Fellow in Psychiatry.

On the afternoon of Oct. 11, 1928, at 4:15 o'clock, the new marble parapet in front of the Harvard Medical School was dedicated midst a military atmosphere. The monument was erected in memory of those men of Base Hospital No. 5 who were killed overseas. Dr. Harvey Cushing, Colonel of the unit, presided.

The ceremony was opened by a prayer offered by Dean P. F. Sturges of the Cathedral Church of St. Paul. General C. R. Edwards then told how the Harvard unit was one of the first six to go over and how by overcoming much of the army red tape and individual valor and sacrifice they did magnificent work. Surgeon-General Ireland told of how these units responded to the call of England in 1917 when she found herself short of medical men. The Harvard unit began operating in May, 1917, and during an air raid lost the first enlisted man and first officer from the American army to be killed during the war. President Lowell of Harvard University gave a short address. Dr. Harvey Cushing then told why the parapet was erected. When the unit first went overseas, some Boston friends collected a company fund. This was not expended overseas and when the company returned, the money was used to help needy men of the unit. Now, it was used to raise the monument which in a way symbolizes the sandbags and trenches of France.

To the tune of the Star-Spangled Banner and Taps, rendered by the Coast Artillery Band from Fort Banks, the ceremony ended.

THE APPOINTMENT OF DR. DUCKETT JONES —Dr. Duckett Jones has been appointed Resident Physician at the House of the Good Samaritan and Assistant in Medicine at the Harvard Medical School beginning October 1st.

NOTICES

Attention is called to the lecture by Professor H. H. Dale to be given in Building C amphitheatre, Harvard Medical School, at 5 P. M. on Friday, October 19. As stated in the item of the Harvard Medical School news which appears elsewhere on this page, the lecture is open to the medical profession, medical students, and others who may be interested.

THE MASSACHUSETTS CENTRAL HEALTH COUNCIL

Physicians, nurses, and others interested in public health are cordially invited to attend the dinner meeting of the Massachusetts Central Health Council to be held at Hotel Bancroft, Worcester, Massachusetts, on the evening of Wednesday, October 31. Tickets are $2.00. The dinner will begin at 6:30 o'clock. Dress will be informal.

The subject for discussion is "Desirable Relations Between the Medical Profession and Public Clinics". The speakers will be Dr. George H. Bigelow, State Commissioner of Public Health, and Dr. Alec N. Thomson, Secretary of the Public Health Committee of the Medical Society of the County of Kings, Brooklyn, New York.

Reservations should be sent to Frank Kiernan, Secretary-Treasurer, 1149 Little Building, Boston, Massachusetts.

SUFFOLK DISTRICT MEDICAL SOCIETY

CENSORS' MEETING

The Censors of the Suffolk District Medical Society will meet for the examination of candidates at the Medical Library, No. 8 The Fenway, Thursday, November 1, 1928, at 4:00 o'clock.

Candidates should make personal application to the Secretary, and present their medical diploma at least one week before the examination.

ARTHUR H. CROSBIE, *Secretary.*

520 Commonwealth Avenue.

NOTICES OF MEETINGS

HARVARD MEDICAL SOCIETY

The first meeting of the Harvard Medical Society will be held in the Amphitheatre of the Peter Bent Brigham Hospital at 8 p. m., on Tuesday, October 23.

Program: (1) Presentation of cases. (2) Hypophyseal Growth Principles, Dr. Harvey Cushing. (3) Experimental Acromegaly, Dr. Tracy Putnam.

WILLIAM P. MURPHY, *Secretary.*

TRUDEAU SOCIETY

The next meeting of the Trudeau Society of Boston will be held on Tuesday evening, November 13, 1928, at 8:15 p. m., in Sprague Hall, Boston Medical Library, 8 The Fenway, Boston.

The speaker will be Dr. Harlan F. Newton of Boston; subject: "Observations of the Surgical Treatment of Pulmonary Tuberculosis in Europe."

Physicians, medical students and nurses are cordially invited to attend this meeting.

RANDALL CLIFFORD, *Secretary.*

BOSTON MEDICAL HISTORY CLUB

The first meeting of the year will be held at the Boston Medical Library, 8 The Fenway, Monday, October 22, 1928, at 8:15 P. M.

The Warren Stock and its Scions, David Cheever, M.D.

J. C. Warren—the Man, Frederick C. Shattuck, M.D.

Dr. John Warren, John L. Bremer, M.D.

Demonstration of Warren memorabilia, James F. Ballard.

EDWARD W. TAYLOR, M.D., *President.*
JAMES F. BALLARD, *Secretary.*

SOCIETY MEETINGS

October 19—Massachusetts Psychiatric Society. Detailed notice appears on page 750, issue of October 11.

October 19, 20—Annual meeting of the Academy of Physiotherapy. See page 750, issue of October 11, for complete notice.

October 22—Boston Medical History Club. For complete notice see above.

October 23—Harvard Medical Society. Complete notice appears above.

October 23-24—The autumn meeting of the State Nurses' Association. For complete notice see page 649, issue of September 27.

Combined Meetings of the Boston Medical Library, the Suffolk District Medical Society, the Middlesex South District Medical Society and the Norfolk District Medical Society

October 31, 1928—Stated meeting. Symposium by the Staff of the Children's Hospital. See notes under Suffolk District Medical Society (page 800, this issue).

November 21, 1928—Meeting in association with Norfolk District Medical Society. Dr. Frederick W. O'Brien will read the paper entitled "Recent Advances in Physical Therapy" and Dr. Edwin T. Wyman will open the discussion.

December 19, 1928—Surgical Section. Symposium on Stomach Surgery. "Operative Procedures; Indications and Results," Dr. R. H. Miller; "Selection and Management of Patients for Gastric Surgery," Dr. H. M. Clute; "Acute Perforations of Stomach and Duodenum," Dr. W. R. Morrison; "Results of a Series of Stomach Operations," Dr. E. S. Emery, Jr. Discussion by Doctors David Cheever, Edward P. Richardson, Frank H. Lahey and I. J. Walker.

January 30, 1929—General meeting in association with Boston Medical Library. "Heredity," Professor George H. Parker, Harvard University.

February 27, 1929—Medical Section. "The Newer Knowledge of Nutriment," Dr. Lafayette B. Mendel (exact title to be submitted later), Yale University Medical School.

March 27, 1929—Meeting in association with Middlesex South District Medical Society. Clinical and Experimental Studies of Obstructing Jaundice and Its Complications. Dr. Waltman Walters, Mayo Clinic.

April 24, 1929—Annual meeting. Speaker, Dr. Walton Martin, New York City. Title to be announced later.

The medical profession is cordially invited to attend all these meetings.

November 9-10—New England Surgical Society, Tenth Meeting. Complete notice appears on page 542, issue of September 13.

November 13—Trudeau Society. Complete notice appears elsewhere on this page.

December 3-7—Radiological Society Convention. Detailed notice appears on page 712, issue of May 17.

DISTRICT MEDICAL SOCIETIES

Barnstable District Medical Society

Schedule of Meetings: November 1, 1928, February 7, 1929, May 2, 1929.

Bristol North District Medical Society

April 18, 1929—Spring meeting.

Bristol South District Medical Society

Meetings will be held November 7, 1928, and May 2, 1929. Complete notices will appear later.

Essex North District Medical Society

November 1, 1928 (Thursday)—Censors meet at Hotel Bartlett, 95 Main Street, Haverhill (Tel. 3430), at 2 P. M.

January 2, 1929 (Wednesday)—Semi-annual meeting at Haverhill, at 12:30 P. M.

May 1, 1929 (Wednesday)—Annual meeting at Lawrence, at 12:30 P. M.

May 2, 1929 (Thursday)—Censors meet at Hotel Bartlett, 95 Main Street, Haverhill, at 2 P. M. (Tel. 3430.)

Essex South District Medical Society

November 1, 1928 (Thursday)—Censors meet for examination of candidates at Salem Hospital at 3:30 P. M. Candidates should apply to the Secretary (Dr. R. E. Stone, Beverly) at least one week prior.

November 7, 1928 (Wednesday)—Salem Hospital. Clinic at 5 P. M. Dinner at 7 P. M. Speaker: Dr. Harry Solomon, Boston. Subject: Syphilis of the Nervous System. Discussion by Drs. W. V. McDermott of Salem and C. A. Bonner of Hathorne (10 minutes each). Discussion from the floor.

Further announcements will follow.

Franklin District Medical Society

Meeting will be held on the second Tuesday of November, January, March and May.

Hampshire District Medical Society

December 12—Address by Dr. Philemon Truesdale.

March 13, 1929—Address by Dr. George E. Gage, Professor of Bacteriology and Physiology at the Massachusetts State College.

Middlesex East District Medical Society

The following schedule of meetings has been arranged for the coming year:

November 14—Woburn.
January 16—Wakefield.
March—Reading.
May—Melrose.

Subjects and speakers to be arranged by committees in each city or town.

Middlesex North Medical Society

The winter meeting will be held the last Wednesday in January.

The annual meeting will be held the last Wednesday in April.

Middlesex South District Medical Society

March 27, 1929—Joint meeting with the Suffolk and Norfolk Districts.

April, 1929—Annual meeting. Definite date to be announced later.

Norfolk District Medical Society

Below are the proposed meetings of the Norfolk District Medical Society for the 1928-29 Season. The schedule below will be adhered to as strictly as possible. The carrying out of the proposed plan will, of course, depend upon the acceptances of invitations extended to the speakers. Minor changes may be necessary.

October 30—Pondville Hospital. Dr. Lyman F. Jones, Superintendent. Inspection, 4 P. M.; Business Meeting at 5:30; Papers by the Staff; Collation.

November 21—Boston Medical Library. In combination with Suffolk District and Middlesex South District Societies. Subject, Recent Advances in Physical Therapy. Dr. Frederick W. O'Brien and Dr. Edwin T. Wyman.

January 29—Roxbury Masonic Temple. Subject, Treatment of Varicose Veins by the Injection Method—Dr. E. E. O'Neil. Dr. Homans will open the discussion.

February 25—Roxbury Masonic Temple. Dr. W. R. Ohler. Subject to be announced. Discussion to be opened by Dr. A. A. Hornor.

March 29 — Roxbury Masonic Temple. Subject and speakers to be announced.

May, 1929—Annual meeting program to be announced.

The Censors of the Society meet November 8, 1928, and May 9, 1929, at the Roxbury Masonic Temple, Warren Street, Roxbury, at 4 P. M., for the examination of candidates.

Suffolk District Medical Society

October 31, 1928 (Wednesday), at 8 P. M.—Children's Hospital, 300 Longwood Avenue, Roxbury. Stated meeting. Symposium by the Staff of the Children's Hospital: "Sepsis of Bones and Joints," Dr. Robert B. Osgood; "Moving Pictures as Hospital Records," Dr. Kenneth D. Blackfan; "Fractures of the Lower End of the Humerus," Dr. William E. Ladd; "Foreign Bodies in the Bronchus," Dr. Lyman G. Richards. This symposium will be held in the amphitheater of the Children's Hospital. Entrance on Vila Street, Roxbury.

November 1—Censors' meeting. See page 799 for detailed notice.

March 27, 1929—Meeting in association with Middlesex South District Medical Society. "Clinical and Experimental Studies of Obstructive Jaundice and Its Complications," Dr. Waltman Walters, Mayo Clinic.

April 24, 1929—Annual meeting. Speaker, Dr. Walton Martin, New York City. Title to be announced later.

LINCOLN DAVIS, M.D., President.
ARTHUR H. CROSBIE, M.D., Secretary.

Worcester North District Medical Society

October 23, 1928 (Tuesday)—At Gardner State Colony, by invitation. Program by Staff Colony.

January 22, 1929 (Tuesday)—At Henry Heywood Memorial Hospital, Gardner, by invitation. Program by Staff.

Annual meeting the fourth Tuesday in April.

BOOK REVIEWS

"The Examination of Patients"—NELLIS B. FOSTER, M.D. Second Edition revised—392 Pages. W. B. Saunders Co., 1928.

The second edition of this book sustains the high degree of merit present in the first edition. Between the covers of this comparatively small volume a great many of the essentials of medicine will be found. Inevitably, as the author points out, systematic examination leads to systematic diagnosis. The technique of the physical examination is excellently described and physical signs of abnormal conditions are briefly presented.

In the section on the lungs the author has not merely presented a list of signs but has reverted to the fundamental principles of physics on which these signs are based. The result is that one can introduce reason in the physical diagnosis and not merely memory.

Modern Practice Of Pediatrics. WILLIAM PALMER LUCAS, M.D., LL.D. Publisher: The Macmillan Company, New York.

This treatise on Pediatrics is an innovation among text books on this subject. A method of presentation has been adopted which is an effort, as stated in the author's preface, "to relate the study of diseases of childhood to positive aspects of health." The work consists of two parts, first, dealing with infancy and the second with childhood. The introductory chapters discuss principles in Pediatrics and the development of preventive Pediatrics. These are followed by chapters discussing the importance of the prenatal period and postpartum care of the mother in relation to infant life. A careful historical account of Pediatrics is given together with careful statistical arguments to show what has been accomplished by preventive medicine in this field. The remainder of the first part of the book deals with the conventional or "orthodox" conditions of infancy with careful clinical descriptions and references to scientific advances as related to the subject under discussion. The chapter on artificial feeding illustrates well the author's effort to bring before students and those interested in children's diseases the consensus of views in regard to our present-day methods. He rightfully advocates the simplified use of whole milk dilutions as now in vogue. The second part of the text on childhood gives introductory chapters on development, the effect of diet on health and then takes up the diseases of the various "systems". If one should select various chapters such as those on cardiac disease and respiratory infections as examples, they would show the author's endeavor to bring the subject matter up to date with emphasis on the preventive side. The book contains after each chapter very valuable "reading references". The text consists of 962 pages, well illustrated and arranged. A reviewer of such a text always questions rightfully the value of a new treatise when there are already standard text books on this subject. In this instance there seems to be no doubt but that the author has made a definite contribution in presenting a subject from a modern point of view, retaining still the classical essential descriptions of disease. It is a book to be heartily recommended to students and practitioners who are interested in children.

The JOURNAL does not publish the price of books received for review because of Postal regulations. Requests for this information addressed to the JOURNAL office will receive early attention.